Hospital for Special Care

Hospital for Special Care
2150 Corbin Avenue
New Britain, CT 06053

HIM Phone: 860-827-4863
HIM Fax: 860-827-4837
www.hfsc.org

REQUEST TO RELEASE MY HEALTH RECORDS TO HOSPITAL FOR SPECIAL CARE

Patient Name: ______________________________________ **DOB:**______________________

I, the undersigned patient (or legal representative), hereby authorize ____________________________________
(Print name of facility/office releasing the records)
to release the information listed below for the purposes of continuity of care to Hospital for Special Care (HSC).

If known, please specify the name of the individual, department or outpatient clinic at HSC and the specific contact information to which the records should be released.

Name/Dept./Clinic:

Address:
2150 Corbin Avenue, New Britain, CT

(860) (860)
Fax number Phone number

Dates requested: Records covering from _______/_______/________ **to** _______/_______/________

[ ] **Continuing Care documents** (includes: Next of Kin/Personal Representative, Primary Care Provider, Advance Directives, Problem List, Family History, Social History, Allergies/Adverse Reactions/Alerts, Medications, Immunizations, Procedures and Discharge Summary)

[ ] Discharge Summary
[ ] Discharge Instructions
[ ] History & Physical Exam
[ ] Consultation Reports
[ ] Clinical Progress Notes/Assessment
[ ] Procedure Notes/Operative Report
[ ] Pathology Report
[ ] Lab Reports
[ ] Radiology

[ ] Speech Therapy
[ ] Physical Therapy
[ ] Occupational Therapy
[ ] Psychiatric/Behavioral Health Notes
[ ] Abstract of Record
[ ] Operative Report
[ ] Outpatient Records Only

Other (please specify):____

1. I understand that this authorization will expire one year after I have signed the form, or other date as specified here: _____/_____/_______.
2. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing, and it will be effective on the date HSC is notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment at HSC.

* ______________________ * ______________________ * ______________________
Patient Signature (or authorized representative) **Print Name** **Date**

Patient unable to sign due to: ____

Relationship to patient: ☐ Parent ☐ Guardian ☐ Conservator ☐Executor of Estate ☐Health Care Representative

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under 18 years old) or a legal guardian has been appointed. Emancipated minors (age 16 and court ordered) may sign their own authorization for release of all medical records. Minors also may sign their own authorization for release of records related to drug/alcohol abuse treatment, sexually transmitted disease, HIV testing and treatment, and mental health treatment, if the minor is authorized to give consent to treatment under state law.