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

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

AUTHORIZATION FOR ACCESS/RELEASE OF HEALTH INFORMATION

Step 1.

Patient Name: _____ _____ ____ _____
(Last) (First) M.I. Preferred Name

Maiden/Other Names:_____ Date of Birth: _____/_____/_____

Address: _____ City_____ State_____ Zip_____

Phone #:_____ Email:_____

Step 2.

I hereby request Hospital for Special Care to:

☐ **Release my medical record TO:** ☐ **Obtain Information FROM:**

Name/Contact Person: _____ Department (if applicable):_____

Address: _____ City_____ State_____ Zip_____

Phone #:_____ FAX #:_____

Email:_____ Relationship to patient: _____

Step 3.

Purpose of sharing information:

☐ I would like a copy of my medical record
☐ Legal
☐ Workers' Compensation
☐ Insurance
☐ Personal/Other_____
☐ Medical/Continuity of Care
☐ Disability
☐ Social Security/Disability Benefits
☐ Veteran Benefits

Step 4.

Method of Disclosure/Format:

☐ Follow My Health Patient Portal
☐ Paper
☐ Mail
☐ FAX
☐ Pick up On-site - Please indicate how you would like to be contacted when ready for pick-up: _____
☐ Secure Email* ** HFSC advises against delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, etc.).*

Step 5.

Date(s) of Service or Date Range covered by this request: ☐ Entire Admission or ☐ ____/_____/_____ to ____/_____/_____

[*Form is valid for one year from date of signature unless you specify an Expiration Date.:* _____*]*
Expiration Date

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Step 6.

Type of information to be shared:

[ ] **Abstract of Medical Record** (History and Physical Exam, Discharge Summary, Consult Reports, Procedure Reports, Lab Results, Radiology and Pathology Reports) Abstract will include records from the most recent 6 months unless otherwise specified.

- [ ] Discharge Summary
- [ ] History & Physical Exam(s)
- [ ] Procedure/Operative Report(s)
- [ ] Consult Report(s)
- [ ] Medication List
- [ ] Pathology Report
- [ ] Pathology slides (processed outside HFSC)
- [ ] Lab Results
- [ ] Radiology Reports
- [ ] Outpatient/Clinic Visit Summary/Notes
- [ ] Speech Therapy/Physical Therapy/ Occupational Therapy Notes
- [ ] Test Results – specify Pulmonary Function Test, Cardiac/Stress Test, Echocardiogram/EKG, etc. _____
- [ ] Immunization Record
- [ ] Psychology/Behavioral Health Notes
- [ ] Outpatient Neuropsychology testing results
- [ ] Radiology films (processed outside of HFSC)
- [ ] Itemized Bill
- [ ] Other:_____

[ ] **Complete Medical Record**

I WISH TO EXCLUDE THE FOLLOWING RECORDS FROM DISCLOSURE:

☐ Alcohol, Drug or Substance Abuse ☐ Behavioral Health ☐ Genetic Testing ☐ Sexually Transmitted Disease
☐HIV ☐Other_____

Minors: The patient's parent or legal guardian must sign this authorization if the patient is a minor (under 18 years old) or has a legal guardian. If a minor (age 13 or older) receives treatment for HIV, substance abuse, pregnancy/birth control, or sexually transmitted diseases without parental consent, the minor must sign this form for those records. If patient is a minor (age 16 or older) and received behavioral health treatment without parental consent, the minor must sign this form for those records. Emancipated minors (age 16 and court ordered) may sign this form for release of all types of medical records.

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- If requested, I will be provided with a copy of this form.
- There may be a reasonable cost-based fee for copies of my medical/billing records, as provided by law.
- I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing, and such revocation will be effective on the date received by HFSC except to the extent action has already been taken in reliance upon this authorization.
- I understand that information being disclosed by HFSC pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. However, other laws may prohibit the recipient from further disclosing certain records, such as HIV/AIDS, substance abuse, or mental health treatment records.
- I understand that I am not required to sign this form in order to receive or continue treatment at HFSC, unless HFSC has been requested by a third party to create health information solely for purposes of providing that information to the third party (such as a workers' comp evaluation).

Notice to Recipient of Records –
If this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply:

This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

Return completed form to:

Release of Information – HIM Department
Hospital for Special Care
2150 Corbin Avenue
New Britain, CT 06053

Fax: 860-827-4837
Email: ROI@hfsc.org

Printed Name: _____ **Date:** _____

Print form and sign here >

_____
Signature of Patient or Authorized Representative
** must provide proof of authority (except parent of a minor)

Please check relationship to patient

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative

☐ Conservator ☐ Other Authorized Legal Representative _____ (must provide documentation)

_____ _____ _____
Printed Name of Minor (when applicable) Signature of Minor (when applicable) Date

☐ If Patient is unable to sign due to physical limitations, note the name & title/credentials of staff member who is obtaining this authorization.

_____

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AUTHORIZATION FOR ACCESS/RELEASE OF HEALTH INFORMATION (Continued)

***Please list Additional recipients (if any)*:**

Party to Receive Records from HFSC or Disclose Information to HFSC

Name/Contact Person:_______________________________________ Department (if applicable):____________________
Address: ____ City___________________________ State_____ Zip__________
Phone #:____ FAX #:______________________________________
Email:____ Relationship to patient: _________________________________

Requested Method of Disclosure/Format:
☐ Paper ☐ FAX ☐ Pick up On-site
☐ Secure Email* ** HFSC discourages delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, unencrypted USB drive, etc.).*

Party to Receive Records from HFSC or Disclose Information to HFSC

Name/Contact Person:_______________________________________ Department (if applicable):____________________
Address: ____ City___________________________ State_____ Zip__________
Phone #:____ FAX #:______________________________________
Email:____ Relationship to patient: _________________________________

Requested Method of Disclosure/Format:
☐ Paper ☐ FAX ☐ Pick up On-site
☐ Secure Email* ** HFSC discourages delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, unencrypted USB drive, etc.).*

Party to Receive Records from HFSC or Disclose Information to HFSC

Name/Contact Person:_______________________________________ Department (if applicable):____________________
Address: ____ City___________________________ State_____ Zip__________
Phone #:____ FAX #:______________________________________
Email:____ Relationship to patient: _________________________________

Requested Method of Disclosure/Format:
☐ Paper ☐ FAX ☐ Pick up On-site
☐ Secure Email* ** HFSC discourages delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, unencrypted USB drive, etc.).*

Party to Receive Records from HFSC or Disclose Information to HFSC

Name/Contact Person:_______________________________________ Department (if applicable):____________________
Address: ____ City___________________________ State_____ Zip__________
Phone #:____ FAX #:______________________________________
Email:____ Relationship to patient: _________________________________

Requested Method of Disclosure/Format:
☐ Paper ☐ FAX ☐ Pick up On-site
☐ Secure Email* ** HFSC discourages delivery of information electronically using methods that cannot be secured by encryption (such as personal email address, unencrypted USB drive, etc.).*