MIDDLESEX HOSPITAL

Note to Requestor of Records:
There may be a $.65 per page charge for copies of the medical record.

Authorization to Release or Obtain Information

Name of Patient:_____DOB _____/_____/_____

Address:_____Phone:_____

I hereby authorize Middlesex Hospital / Middlesex Health System to release/obtain all medical information with respect to the treatment of the above-referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

The Name or Specific Identification of Persons to Whom Disclosure: ☐ Records may be released to ☐ Obtained from:

Name:_____ Phone No.:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Indicate Delivery Preference (select one)
☐Mail ☐On-site pick-up
☐Email (Please provide email address)_____

☐ Personal	☐ New Physician	☐ Social Security Disability.	☐ Other:_____
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	_____
☐ Consultation	☐ Workers' Comp	☐ Attorney	

Description of the Information to be Used or Disclosed.

Specific Date(s) of Treatment(s) _____

☐ Abstract (face sheet, history and physical, operative report, discharge summary, consultation, laboratory, radiology)	
☐Surgical (Operative Report, Pathology Report)	☐ Complete Record - specify dates of care:_____ to _____
☐ Complete Emergency Room Record	☐ Test Results (lab, radiology, cardiology, neurology, respiratory)
☐ Therapy notes (physical, occupational, speech, chemo, radiation)	☐ Other

I understand that Middlesex Hospital will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.
I understand that I may revoke this Authorization at any time by providing written notice to Middlesex Hospital. I understand that I may not be able to revoke this Authorization if Middlesex Hospital has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.
I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition:_____
If I fail to specify an expiration date, event or condition, this Authorization will expire in one year.

_____ _____
Date Signature of Patient or Person granting Authorization on behalf of patient

If signed by the Legal Representative, indicate your relationship to the patient below and attach a copy of the documentation:

☐ Conservator ☐ Power of Attorney ☐ Executor of Estate ☐ Other:_____

FOR FAMILY PRACTICE USE ONLY

☐ **90 South Main Street**
Middlesex Hospital
Family Practice Group
90 South Main Street
Middletown, CT 06457
Phone: 860.358.6300
Fax: 860-358-8320

☐ **42 East High Street**
Middlesex Hospital
Family Practice Group
42 East High Street
East Hampton, CT 06424
Phone: 860.358.3500
Fax: 860-358-8322

☐ **595 Main Street**
Middlesex Hospital
Family Practice Group
595 Main Street
Portland, CT 06480
Phone: 860.358.7100
Fax: 860-358-8321

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

> "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

> "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 C.F.R. § 2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits 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 law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)