

Authorization for Access/Release of Information

PATIENT NAME: _____
LAST
FIRST
MI
MAIDEN OR OTHER NAME

DATE OF BIRTH: ____ - ____ - ____ SS#: ____ - ____ - ____ MEDICAL RECORD #: _____
MO
DAY
YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize Yale-New Haven Hospital and related entities to:

release information from my medical record to: obtain information from:

NAME: _____ PHONE/FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Please attach a separate sheet for additional recipients.

Send any obtained information to:

NAME: _____ PHONE/FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) as follows:

- | | |
|---|----------------------------|
| <input type="checkbox"/> Inspection Only | Dates of Service:
_____ |
| <input type="checkbox"/> Copy of Standard Report (includes, as appropriate, discharge summaries, operative notes, results of X-ray and lab tests and history and physical.) | _____ |
| <input type="checkbox"/> Copy of other Medical or Billing Information as specified: | _____ |
| _____ | _____ |
| _____ | _____ |

PURPOSE OF DISCLOSURE:

- | | | |
|--|---|---|
| <input type="checkbox"/> Changing physicians | <input type="checkbox"/> Consultation/second opinion | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> School | <input type="checkbox"/> Insurance (other than payment) | <input type="checkbox"/> Continuing Care |
| <input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> Legal (please specify) _____ | <input type="checkbox"/> At Patient's Request |

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified:

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date 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 privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

No Mental Health No Substance Abuse treatment information No HIV/AIDS

Signature of Patient Date

Print Name

Parent/Legal Guardian/Authorized Person Date

Relationship to patient

Please send completed form to:

**Yale-New Haven Hospital
 Medical Record Department
 Medical Information Unit
 20 York Street
 New Haven, CT 06504**