PROGRESSIVE WOMEN'S HEALTH

499 Farmington Ave | Suite 220 | Farmington, CT 06032

Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information
As required by the Health Portability and Accountability Act of 1996 (HIPAA) and Connecticut Law, a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

Your Name (Print) _____ Date of Birth _____

Other name e.g.; (maiden) _____ Telephone _____

Address _____ City/ State _____ Zip _____

Date(s) of Service for Release _____ OR, the entire Medical Record ☐

I hereby authorize this medical practice, _____ to release my health information to:

____ Progressive Women's Health, 499 Farmington Avenue, Suite 220 Farmington, CT 06032 Phone (860)676-8111 Fax (860) 677-2693

OR ____ Other practice (include name, address, phone number):

_____

Reason for release: **__Ob/Gyn Care OR other:** _____

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. Initial all requested exclusions:

EXCLUSION(S): Alcohol/Drug _____, Behavior/Mental Health/Psychiatric _____, Sexually Transmitted Disease _____, HIV/AIDS _____, Other _____; specify other exclusion _____

I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan. This authorization is effective _____ through _____ (dates must be specified).

Signature: _____ Print Name: _____ Date: _____

If this form is completed by someone other than the patient, please print name, address, and initial below to indicate relationship.

Name: _____ Address: _____

Guardian: _____ Conservator: _____ Parent: _____ Patient's Representative: _____

I understand that I have the right to receive a copy of this authorization.

Refusal to Sign Authorization
I understand that by declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released. I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPAA. However, other State or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

Signature:_____

As referenced in section 20c (b), Connecticut General Statutes allow a charge of $.65 per page to copy medical records, plus the shipping and handling or any conveyance fees this office is required to pay. Fees are payable in advance, by cash or credit card.