PEDIATRICS PLUS* pc
13 Peck Street, North Haven, CT 06473 • (203)239-4627
HIPAA AUTHORIZATION FOR RELEASEOF PATIENT RECORDS

Patient/Client Name:_____ Date of Birth _____

I, _____, hereby authorize the above-named provider to release my medical records, including a copy of my completed and entire mental health record, all records for my care and treatment, included psychiatric and drug information and information regarding my HIV/AIDS status, treatment or testing, emergency room records, nursing notes, laboratory results, pathology reports, x-ray reports, films, and all consent forms, and a copy of the bill for services rendered to:

Name:_____

Address:_____

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist; or any other mental health worker, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of mental health information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations (CFR), which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

The information to be used/disclosed consists of:

_____ **All Records** _____ **Alcohol/Drug Related** _____ **Consultation** _____ **Radiology**

_____ **Immunizations** _____ **Psychiatric/Psychosocial** _____ **Lab Reports** _____ **Other (Specify)**

Dates of Care: From:_____ **To:**_____

The information will be used/disclosed for the following purposes:

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.

I understand that if the person of or the entity that receives the information is not a health care provider or health plan covered by the the federal privacy regulations the information described above may be rediscolsed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information use/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation; except to the extent that action has been taken in reliance on this authorization.

I understand that there will be a $.65/per page charge for any records copied in accordance with the Statutes of the State of Connecticut in addition to the cost of first class postage if mailed.

This authorization expires 1 year from the date this form is signed, unless revoked by the patient or authorized representative.

_____ _____

Signature of Patient/Client or his/her authorized representative, Parent or guardian if a minor, please specify relationship to patient/client. **Date**

If a representative sign, please describe the representative's authority to act on behalf of the patient:

_____

SUBMIT