MEDICAL RECORD RELEASE
(TRANSFER OF RECORDS/ANOTHER PHYSICIAN)

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AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. **By signing this form, you are giving us permission to share your PHI as you indicate below.**

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether or not I sign this authorization. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered under HIPAA, the released information may no longer be protected by federal regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time by signing the revocation section on my copy of this form and returning it to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

Please send my PHI directly to the Physician's Office listed below:

Patient Name Printed: _____

Physician's Name: _____ Group Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ I understand that the PHI sent by the Practice will be information about me that is maintained in the Practice's designated record set.

☐ I understand that this authorization is valid for one year from the date below unless I specify a date here: _____

_____ _____ _____
Patient or Representative Signature Relationship to Patient Date

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

Connecticut state law permits us to charge $.65 per page. This fee is all inclusive of labor, copying and postage. Unless otherwise specified, only the most recent findings, progress notes and test results will be provided.

PLEASE SEE REVERSE SIDE

PRACTICE REVIEW SECTIONS:

Date received:	Reviewed by:
Privacy Officer:	Review date:

This request is:

Granted _____ Denied _____ (If the request is denied, indicate the reason why)

Reviewer's Comments:

_____

_____

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization, effective _____/_____/_____.

_____ _____

Patient or Representative Signature Date

_____ _____

Printed Name of Patient or Representative Birthdate

_____ _____

Signature of Practice Privacy Officer Date

If the practice is seeking this authorization from you for a use or disclosure of you PHI, we will provide you with a copy of this signed authorization.