YALE NEW HAVEN HEALTH

Phone: 203-688-2231
Fax: 203-688-4645

Authorization to Release/Disclose Protected Health Information

Patient Name: _____ _____ _____ _____
(Last) (First) (Middle Initial) (Maiden/Other Name)

Date of Birth:_____ **Phone:** _____ **Fax:**_____

_____
Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: ☐ Self ☐ Further medical care ☐ Attorney ☐ Changing Physicians
☐ Disability ☐ Workers Comp ☐ Insurance Eligibility/Benefits ☐ Other _____

I hereby authorize Yale-New Haven Health entity(ies) named below to release information from my medical record to:

Name:_____ **Phone/Fax:**_____

Address:_____ **City/State:** _____ **Zip Code:** _____

Method of Disclosure:

☐ **Mail** ☐ **Pick Up** (Photo ID Required) (Date _____ Time _____ To be Determined by Office Staff)

☐ Fax (Physician or Health Care Providers Only - all information is to be completed

_____
(Name of Physician or Facility)

_____
(Street Address) (City/State) (Zip) (Phone #) (Fax #)

Please indicate records you are requesting by checking boxes below:

☐ Yale-New Haven Hospital ☐ Hospital of Saint Raphael prior to 09/12/2012 ☐ Bridgeport Hospital ☐ Greenwich Hospital
☐ Northeast Medical Group ☐ Smilow Care Center ☐ Cardiology ☐ Urology

Release Content: Date(s) of service requested: From: _____To: _____

☐ History & Physical	☐ Path Report	☐ Lab Results	☐ Stress Test
☐ Discharge Summary	☐ ED Record	☐ X-ray CD	☐ Laboratory Results
☐ Emergency Visit	☐ Progress Notes	☐ X-Ray Report	☐ Billing Record
☐ Procedure/Operative Report	☐ PT/OT/Speech Notes	☐ Pathology Report	☐ Echocardiogram
☐ Immunization	☐ Cancer Center	☐ EKG	☐ Other_____

For Internal Use Only: MRN:_____ **CSN:** _____

HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. **(Any records containing any of this information requires signature from age 13 and older to sign for release of records)**

Indicate which you do NOT want released with your initials:

____HIV ____Substance Abuse which includes Alcohol & Drug Abuse ____Pregnancy Test ____ Genetic Testing

_____Behavioral Health/Psychiatric _____Sexually Transmitted Disease _____Other (please list)_____

- The authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing the YNHHS Medical Information Unit. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- I understand the information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization of by federal privacy regulations.
- I understand that this authorization is voluntary and my treatment by YNHSS is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- I understand that I may see and copy the information described on this form if I ask for it. There is a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18).

Authorization can be sent to: **Medical Information Unit**
PO Box 9565
New Haven, CT 06535

Printed Name: _____ Date: _____ Time:_____

_____
Signature of Patient or Authorized Representative
***must provide proof of authority (except parent of a minor)*

Please check relationship to patient and if other than patient, reason patient cannot sign

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative ☐ Conservator
☐ Other Authorized Legal Representative _____(indicate)
Reason - ☐ Incompetent ☐ Disabled

AUTHORIZATION FOR PERSONAL REVIEW OF MEDICAL RECORD
I request that I be permitted to review my medical record. I understand that any amendments can be requested by doing so on the Patient Amendment Form.

Printed Name: _____ Date: _____ Time:_____

Patient's Signature: _____ Phone (required) _____

You will be notified by phone for appointment time to view