

Milford Hospital
300 Seaside Avenue, Milford, CT 06460
(203) 876-4217 PHONE
(203) 876-4220 FAX

AUTHORIZATION FOR RELEASE OF YOUR HEALTH INFORMATION

Patient name: _____ **Date of birth:** _____

Phone # _____ **MRN:** _____

Address:

I authorize Milford Hospital to use or disclose my health information as described below to the following individuals or entities:

MYSELF

1. _____

OTHER (list addresses below)

2. _____

RELEASE CONTENT: Dates of Service: _____

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Path Report | <input type="checkbox"/> Lab | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Discharge Sum | <input type="checkbox"/> ED record | <input type="checkbox"/> X-ray | _____ |
| <input type="checkbox"/> H & P | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> EKG | <input type="checkbox"/> Billing Record |
| <input type="checkbox"/> Op Note | <input type="checkbox"/> Nursing Notes | <input type="checkbox"/> Stress test | |
| <input type="checkbox"/> Proc Note | <input type="checkbox"/> PT/OT/Speech Notes | <input type="checkbox"/> Echocardiogram | |

SENSITIVE MATERIALS: I authorize release of information about the following sensitive information if it is contained within the medical record: (if your entire medical record is being released, check those pieces of highly sensitive health information you authorize released):

- | | |
|--|--|
| <input type="checkbox"/> Social Work Counseling | <input type="checkbox"/> HIV Test Results* |
| <input type="checkbox"/> Sexual Assault Counseling | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Domestic Violence Victim Counseling | <input type="checkbox"/> Alcohol and Drug Abuse records* |
| <input type="checkbox"/> Psychiatric Information* | <input type="checkbox"/> Other: List Specific items: _____ |

* *By Law, the information below requires a specific signature and will only be released if it is signed for below:*

HIV TEST RESULTS: _____

HIV/AIDS (in the event that information released constitutes confidential HIV related information protected under Chapter 368 of the Connecticut General Statutes): _____

DRUG/ALCOHOL ABUSE (In the event that the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations(42 CFR Part 2): _____

MENTAL HEALTH INFORMATION (in the event that information released constitutes privileged psychiatric-patient communication. Confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes): _____

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REASON FOR DISCLOSURE: My health information is being released or disclosed for the following reasons:

- | | |
|---|--|
| <input type="checkbox"/> Personal | <input type="checkbox"/> Research and Research Oversight |
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Insurance Eligibility/Benefits | |

I understand that this authorization is voluntary. If I do not sign this form, my health care by Milford Hospital will not be affected. 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 once my information is released, it may no longer be protected by federal privacy regulations.

I understand that I may see and copy the information described on this form if I ask for it.

I understand that this authorization will expire: _____
 (Not to exceed 180 days)

I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by notifying Milford Hospital's Privacy Officer in writing. Cancellation of the authorization will not apply to information that has already been released based on this authorization.

I understand that Milford Hospital may receive compensation for medical record copying in accordance with Connecticut law.

Rates

Physician and other health care providers for follow- up care	No Charge
Amount charged per page	\$.65

Signature of patient or patient's representative Date Print Name of Patient
(Do not sign until the information above is filled in completely.)

If Authorized Representative signs form, please check reason:

- Patient is: Minor Incompetent Disabled Deceased Legal Authority Custodial Parent
 Legal Guardian Executor of Estate Deceased Power of Attorney Authorized Legal Representative