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: _____

□ Face Sheet	□ Path Report	□ Lab	□ Other _____
□ Discharge Sum	□ ED record	□ X-ray	_____
□ H & P	□ Progress Notes	□ EKG	□ Billing Record
□ Op Note	□ Nursing Notes	□ Stress test	
□ Proc Note	□ PT/OT/Speech Notes	□ 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):

□ Social Work Counseling	□ HIV Test Results*
□ Sexual Assault Counseling	□ Sexually Transmitted Diseases
□ Domestic Violence Victim Counseling	□ Alcohol and Drug Abuse records*
□ Psychiatric Information*	□ 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): _____

Milford Hospital
AUTHORIZATION FOR RELEASE OF YOUR HEALTH INFORMATION

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

- □ Personal
- □ Further medical care
- □ Legal Investigation or Action
- □ Insurance Eligibility/Benefits
- □ Research and Research Oversight
- □ Changing Physicians
- □ Other _____

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 Hospitalôs 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