Greater New Haven OBGYN Group, PC

Authorization Form for Disclosure/Release of Protected Health information (PHI)
General Health Information/Drug/Alcohol/Psychiatric/HIV Related Information

Phone: ____________

Fax: ____________

Patient: ______________________ **Date of Birth:** ____________ **Date:** ____________

Address: ______________________________________ **Telephone #:** ____________

1. (a) I hereby authorize the Greater New Haven OBGYN Group, PC to receive my record from

   Name: ______________________ Address: ______________________

   (b) I hereby authorize the Greater New Haven OBGYN Group, PC to release my records to

   Name ______________________ Address: ______________________

2. **The purpose for such Information is:** ______________________

3. **Type of Service:** ____Inpatient ____Outpatient ____Emergency Room

4. **Requested Data:**

   ____ All Records
   ____ Medical/Surgical abstract (summary)
   ____ Alcohol/Drug Related
   ____ Psychiatric/Psychosocial
   ____ Immunization
   ____ Physical Therapy
   ____ Other (specify): ______________________
   ____ Other (specify): ______________________

Specific Report(s) - check all that apply

- ☐ Consultation
- ☐ Discharge Summary and Diagnosis
- ☐ Emergency Room Report
- ☐ EKG/EEG
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Operative Report
- ☐ Progress Notes
- ☐ Pathology Report
- ☐ Radiology: ____ Report ____ Films
- ☐ Other: ______________________

5. **Approximate Date(s):** ______________________

6. This form serves the dual purposes of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations- The information to be released may contain information pertaining to psychiatric, psychological, drug and/or HIV or AIDS testing, diagnoses or treatment.

7. I understand there may be a 65-cent/per page copy fee charged with certain requests for my health information. I have 30 days to receive a copy of my records unless otherwise specified. I understand my records may be located through the healthcare system and more than one authorization may be required to obtain all records.

8. I understand my right as stated in the Greater New Haven OBGYN Group, PC Notice of Privacy to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to the department that maintains my requested information. I understand the revocation will not apply to information that has already been released in response to this authorization_ Unless otherwise revoked, this authorization will expire upon the earlier of 60 days from today's date of a specific date, event, or condition to such revocation.

9. I understand authorizing the disclosure of this health information is voluntary- I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or copy the information to be used or disclosed according to state and federal law, and as stated in the Privacy Notice of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized redisclosure.

______________________ ______________________

Signature of Patient or Legal Representative **If Legal Representative, specify relationship**

☐ The patient is a minor, ____ years of age.
☐ The patient is unable to authorize because: ______________________

______________________ ______________________

Signature of Witness **Date**

Notarized signature is required for patients requesting a copy of his/her medical record for personal use.

On this the ____ day of ________, 20____ before me, ______________________, the undersigned officer, personally appeared ______________________, known to me (or satisfactorily proven) to be the person whose name subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof I hereunto set my hand.

Signature Notary Public ______________________ My Commission Expires: ____________

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6 Woodland Road
Madison, Connecticut 06443
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