Hartford HealthCare
St. Vincent's Medical Center

AUTHORIZATION TO RELEASE / DISCLOSE PROTECTED HEALTH INFORMATION

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

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

Date of Birth:_____ Phone:_____

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

This information is to be used for purpose of: ☐ Self ☐ Medical Care ☐ Attorney ☐ Disability ☐ Workers Comp
☐ Insurance Eligibility/Benefits ☐ Other_____

I hereby authorize St. Vincent's entity(ies) named below to ☐ release ☐ receive (select one) information to/from:

Name:_____

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

Method of Disclosure:
☐ Mail ☐ Faxed ☐ Pick Up (Photo ID Required) ☐ Secure electronic medium (if applicable, thumb drive or secure email:___)

Please indicate records you are requesting by checking boxes below:
☐ St. Vincent's Medical Center ☐ St. Vincent's - Westport Campus ☐ Wound Care Center
☐ Outpatient Behavioral Health: ( ) Norwalk ( ) Bridgeport
☐ Urgent Care Center: ( ) Bridgeport ( ) Shelton ( ) Monroe ( ) Fairfield ( ) Milford ( ) Stratford ( ) Trumbull
( ) Other:_____

☐ Multispecialty Group: Physician Name:_____

Release/Receive Content: Date(s) of service requested: From:_____ **To:**_____

☐ Discharge Summary
☐ History & physical examination
☐ Consultation reports
☐ Emergency Dept. record
☐ Rehabilitation Dept. notes
☐ Outpatient Behavioral Health notes
☐ Radiology films/images
☐ Radiology reports
☐ Inpatient record, including Psychiatric Inpatient
☐ Laboratory tests
☐ Pathology slides
☐ Outpatient
☐ Entire record
☐ Other (please specify):_____

Copy to Patient Upon Request

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MRN:_____ **FIN:**_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse (Any records containing any of this information requires signature from age 13 and older to sign release of records).

Please do not release the following information:_____

_____

_____

_____

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 365 days or on the following date, event or condition:

_____

(List specific event, date or condition)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or have copies made of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Services Department. I understand that there is a charge for copies in accordance with Connecticut law.

_____ Date_____

Signature of Patient or Authorized Representative

Relationship to Patient if not signed by patient:_____

Reason for signature other than patient:_____

Must provide proof of authority (except parent of a minor)

☐ Identity Validated by: (St. Vincent's Employee):_____

Verified by: (Form of ID) _____