Greenwich Pediatric Associates

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name_____Date of Birth_____

I hereby authorize Greenwich Pediatric Associates to release my medical health records including the information requested below. I understand that if I am requesting the entire health record or any visit notes, these documents may contain information regarding drug/substance use, reproductive health, mental health concerns, and HIV/AIDS.

Released records will NOT include consultant physician notes, which should be requested from that physician's office directly.

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, this signed form will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment.

____Immunization Record

____Growth Charts

____Well Child Visit Notes

____Sick Visit Notes

____Medication List

____Laboratory Results

____Pathology Reports

____X-ray Reports

____Emergency Room Records

____**Entire medical record**

If other records are requested, please describe below:

_____

_____

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations, which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

Greenwich Pediatric Associates

Patient Name_____Date of Birth_____

The information will be used/disclosed for the following purposes:

_____

_____

If request is due to transfer to another physician, please circle the reason below:

Relocation / To “Adult Physician” / Change of Insurance (which?_____)

Other (please explain): _____

RELEASE/SEND TO: _____

_____

_____

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

Name_____ Relationship to Patient _____

Signature_____ Date_____

PLEASE NOTE: We must ask you to show ID if you are picking up your records. If someone other than the parent/responsible party picks up records they will be required to present written permission to do so from the parent/responsible party.

PLEASE SEE THE FOLLOWING PAGE OF THIS FORM FOR SPECIAL DISCLOSURE INFORMATION REGARDING MENTAL HEALTH, DRUG AND/OR ALCOHOL ABUSE, AND HIV-RELATED INFORMATION.

TO THE RECIPIENT OF THESE MATERIALS:

HIV/AIDS INFORMATION:

In the event that any of the disclosed information includes HIV/AIDs information, this is protected under state law as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Any oral disclosure shall be accompanied or followed by the above notice. See Connecticut General Statute section 19a-585.

PSYCHIATRIC COMMUNICATIONS:

If the released material contains confidential psychiatric communication, as designated in C.G.S. sections 52-146d through 52-146i, inclusive, please note the following:

> "The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes." A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT:

No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and\or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and\or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." See Connecticut General Statute section 17a-688.