CONNECTICUT GI

AUTHORIZATION for RELEASE of HEALTH INFORMATION

Please complete and fax back to: 860-947-4838

Patient Name:_____ Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____ Zip code:_____

I authorize Dr._____

Address:_____ City:_____ State:_____ Zip code:_____

Telephone Number: _____ Fax Number:_____

to release my health Information starting with the date from:_____ to present.

Send Records to:

Dr._____

Address:_____ City:_____ State:_____ Zip code:_____

Telephone Number: _____ Fax Number:_____

I request the information below to be released: (check all that apply)

___Medical History/ Examination reports ___X-Ray ___Complete Medical Record ___Prescriptions

___Hospitalization ___EKG ___Other_____

Purpose for the disclosure:

___At the request of the patient

___Transferring from practice

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal standards, the information disclosed pursuant to this authorization may no longer be protected by federal privacy standards. I understand that state law prohibits the use and/or disclosure of the PHI listed below unless specifically authorize by me. I understand that such information will not be used or disclosed unless I indicate by initialing below.

Mental Health Psychiatric (initials) _____

HIV Tests & Related Information (initials) _____

Alcohol and/or Substance Abuse (initials) _____

I understand that I may refuse to grant consent to release this type of information.

I understand that I have the right to:

- Revoke this authorization except If the organization listed has acted upon this request prior to my request of revocation
- Refuse to sign this revocation
- Receive a copy of this revocation

Expiration Date: Unless I revoke this Authorization or provide a different expiration date below, this Authorization will expire twelve (12) months from the date of execution.

Other Expiration Date:_____/_____/_____

Patient Signature:_____ Date:_____/_____/_____

Legal Representative:_____ Relationship to Patient:_____