Medical Records Request

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____

Previous Names (if applicable) _____ Phone _____

Parent/Guardian Name (Completing Form) _____

Patient Address _____ City, State, Zip _____

I hereby authorize Connecticut Children's to ❑ **Release** my records to **OR** ❑ **Obtain** my records from

Name _____ Phone _____

Address _____ City, State, Zip _____

Method of Disclosure (Select one option)

❑ Mail ❑ E-mail _____

❑ Pick-Up (indicate how to contact you when records are ready) _____

❑ MyChart (must have active account) ❑ Fax _____

Purpose of Disclosure

❑ Medical ❑ Legal ❑ Disability ❑ Insurance ❑ School ❑ Personal Use ❑ Other_____

Medical Information Requested

Dates of Treatment / Date Range (Required) _____

❑ Office Note (Provider/Specialty) _____

❑ History & Physical ❑ Discharge Summary ❑ Operative Reports ❑ Immunizations

❑ Laboratory Report ❑ Pathology Report ❑ Radiology Report ❑ Emergency Room Record

❑ **Abstract of Record** (includes all of the above)

❑ **Entire Record** (includes all of the above AND nursing flowsheets, orders, ancillary notes, etc.)

❑ Radiology Images (CD) ❑ Itemized Bill

❑ Other _____

If records are for an UPCOMING appointment, please specify date of appointment: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Connecticut Children's and/or Connecticut Children's Specialty Group to use and/or disclose my protected health information (PHI) as provided above. **I understand that the records released may contain information relating to mental health/psychiatric care, alcohol and/or substance abuse, HIV related information, reproductive health care, and gender affirming care unless I opt out below.** I understand that I may revoke authorization by sending a written letter to the Health Information Management (HIM) Department. Any such revocation will not apply to information that has already been released in reliance on this authorization. I understand that my/my children's treatment or payment of services is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that once the PHI listed below is used or disclosed as set forth in this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. This authorization form will expire twelve months from the date of execution unless I revoke this authorization.

NOTICE REGARDING INCLUSION OF HIV/AIDS, BEHAVIORAL HEALTH, DRUG & ALCOHOL ABUSE, AND REPRODUCTIVE HEALTH INFORMATION. Information: The medical record includes all of the patient's health information, including any information related to HIV/AIDS, mental health, drug & alcohol abuse, reproductive health care, and gender affirming care ("Sensitive Information"). The medical records released as requested in this document will include any Sensitive Information unless you request that Sensitive Information be excluded by checking the box(es) below.

Please **DO NOT** include the following information:

❑ Mental Health/Psychiatric ❑ HIV Tests & Related Information ❑ Alcohol and/or Substance Abuse
❑ Reproductive Health ❑ Gender Affirming Care ❑ Other _____

Print Name _____

Signature _____ **Date** _____

Check One: ❑ Patient ❑ Parent ❑ Legal Guardian ❑ Other _____

Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or be on record to comply with the above request.

Minor Signature _____ **Date** _____

(Only required if patient is over 13 and records include sensitive information mentioned above)

If medical records are being obtained from an external provider for patient care, please indicate Connecticut Children's provider/office to receive records:

Provider/Office Name _____

Contact Information _____

Please submit completed authorization forms to the below address for processing. To expedite processing please provide a copy of your photo ID.

Connecticut Children's Medical Center
Health Information Management
10 Columbus Blvd – 4th Floor
Hartford, CT 06106
Phone: (860) 837-5780
Fax: (860) 837-5785
Email: HIMROI@ConnecticutChildrens.org