Complete Pediatrics, P.C.
451 State Street North Haven CT 06511 Phone: (203) 248-8888 Fax (203) 248-8889

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

PATIENT NAME_____ **DOB**_____**PHONE #**_____

ADDRESS: _____

I, _____, hereby authorize Complete Pediatrics, P.C. to___ **release**___**receive** my medical health records including a copy of my complete and entire mental health record, all records for my care and treatment, including psychiatric and drug information, and information regarding HIV/AIDs status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered,

TO / FROM (circle one):
NAME:_____
ADDRESS:_____
PHONE: _____ **FAX (Basic Records):** _____

PLEASE SEND RECORDS BY (CHECK ONE) ☐ **FAX** ☐ **MAIL** ☐ **PICK UP IN OFFICE** ☐ **FLASH DRIVE $6.50 FLAT FEE**

☐ **I give COPE, PC permission to put all sibling records on one flash drive**

Email required for Flash Drive: _____

PURPOSE OF RECORD RELEASE

☐**Changing physicians Reason for leaving:** _____

☐**Legal/Attorney/Insurance** ☐ **Other** _____

INFORMATION TO BE RELEASED

☑ **BASIC RECORDS** ***No Charge***: Immunization record, Growth Charts, OR Most recent Well Child Visit

*** ADDITIONAL INFORMATION CAN BE SELECTED BELOW: FEES WILL APPLY when COPE, PC is sending additional information. See information below for record fees.**

☐ **COMPLETE MEDICAL RECORD** ☐ **Other:**_____

☐**ADHD related records** ☐**HIV/STD related records** ☐**Psychiatric/Mental health records** ☐**Substance abuse records**

PLEASE INITIAL ITEMS BELOW

___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 redisclosed and no longer protected by those regulations.

___I understand that I may refuse to sign this authorization and that my refusal to sign will no 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.

___I understand there will be a $6.50 copy fee charged with requests for health information beyond basic records.

This authorization expires 6 months from the date this form is signed, unless revoked by the patient in writing, and properly presented to the records office of the provider listed above.

PARENT/GUARDIAN SIGNATURE or PATIENT 18+SIGNATURE REOUIRED

_____ _____

Signature of Patient or Guardian/Representative **Date**

_____

Relationship to Patient (If a representative signs, describe the representative's authority to act on behalf of the patient)

PLEASE SEE THE REVERSE SIDE 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:

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 by 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 (2 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.