PRIME HealthCare, PC

Gastroenterology/Internal Medicine
44 Dale Road Avon, CT 06001
Phone (860) 674-8830 Fax (860) 674-8984

GI Group
350 Silas Deane Highway, Suite 102, Wethersfield, CT 06109
Phone (860) 529-8670 Fax (860) 529-8790

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

As required by HIPAA and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Subject to the statements on page 2, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: _____ **Date of Birth:** _____

FILL OUT FOR PRIME *Healthcare, PC* **TO DISCLOSE**

I authorize PRIME *Healthcare, PC to* disclose health information to:

Name: _____

Facility: _____

Address: _____

_____

Tele#: _____

Fax#: _____

FILL OUT FOR PRIME *Healthcare, PC* **TO OBTAIN**

I authorize _____
to disclose health information to:

PRIME Healthcare, *PC*

_____ Office/POD

Address: _____

_____

Contact Person: _____

Tele#: _____

Fax#: _____

Method of Disclosure:

□ Pick-up Copy □ Mail Copy □ FAX Copy □ Review

The dates of service and the type(s) of information to be used or disclosed are as follows:

Date(s) of Treatment: _____

□ History & Physical □ Office Visit □ ED Record □ Operative Reports □ Consultations
□ Laboratory Reports □ Radiology Reports □ Radiology Films □ Pathology Reports □ Progress Reports
□ Billing Records □ Entire Pt. Chart □ Other _____

The purpose of this disclosure or use is for the following reason:

□ Medical □ Legal □ Disability □ Insurance □ At the request of the patient

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying my Prime *Healthcare* provider's Office in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by Prime *Healthcare* is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- The parent or legal guardian must sign this authorization if the patient is a minor (under 18) or has a legal guardian.
- Minors receiving drug abuse treatment or treatment for venereal disease may sign their own authorization.

_____ _____

Signature of Patient or Legal Guardian **Date**

Relationship to patient: □ **Self** □ **Parent** □ **Guardian** _____

Witness

□ **Conservator** □ **Executor of Estate** □ **Power of Attorney** □ **Other** _____
(If signed by the Legal Representative attach appropriate documentation to verify authority)

HIV RELATED INFORMATION

In the event that information release constitutes confidential HIV related information protected under Connecticut Law: 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.

PSYCHIATRIC INFORMATION

In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: 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 or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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.