First Choice Health Centers
For All Your Health Care Needs

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East Hartford, Connecticut 06108
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Authorization for Release of Protected Health Information (Medical/Dental Records)

Patient Information

Last Name: **First Name:** **Middle Initial:**
Address: **Telephone:** **Date of Birth:**

I, the undersigned authorize First Choice Health Centers, Inc. to ☐ **DISCLOSE or** ☐ **RECEIVE** protected health information to/from the below indicated entity:

Name:_____
Organization Name:_____
Street Address_____
City:_____ **State:**_____ **Zip Code:**_____
Telephone: (_____)_____ **Fax: (_____)**_____

How may your records be released?

☐ **copies by mail** ☐ **copies by fax (up to 10 pages, otherwise mailed)**
OR ☐ **copies to be picked up - BY WHOM? Name:** _____**(ID WILL BE REQUIRED)**

I authorize the release of my records for the following purpose [MUST *check one*]

☐ **At the request of the patient or the patient's legal representative**

☐ **Other (please specify)** _____

My authorization is for the use and disclosure of the following records:

☐ Entire Medical Record

☐Most Recent Physical Exam

☐Immunization Records

☐Lab Results

☐X-rays and Other Images

☐Dental Record

☐ Other:_____

The following Protected Health Information **will only be released with your signature**:
Alcohol or Drug Abuse:_____
AIDS or HIV:_____
Mental Health/Psychiatric Disorders:_____

If you are not requesting an entire medical record; please indicate the dates of service:
Between: _____/_____/_____ ending on date:_____/_____/_____

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization, the Health Center may not condition my treatment on my provision of this authorization. However, the Health Center may charge a fee for copying and first class postage related to the use/disclosure of my health information under this authorization.
- I may revoke this authorization at any time by written request to the Health Center except where information has already been released in reliance on my authorization.
- This authorization is valid for **one year** from the date I signed it ***OR*** on the following date (*at least 30 days after I signed*):_____.
- The information may be subject to re-disclosure by the recipient and may no longer be protected by the Health Center's privacy practices or applicable privacy law.

ANY INFORMATION RELEASED BY PROVIDER TO AUTHORIZED PERSONS IS SUBJECT TO THE FOLLOWING NOTICES: Drug and Alcohol Abuse Information:

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.

HIV-Related Information:

In the event that information released 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

Patient or Patient's Personal Representative with *legal authority* to act for Patient must sign *and* date this Authorization for it to be valid

_____ _____
Signature of Patient or Patient's Personal Representative Date

RELATIONSHIP TO PATIENT (*circle one*) :

Self Mother Father Legal Guardian Conservator Other (*please specify*) _____