East Haven Pediatrics, PC
300 Main Street, East Haven, CT 06512
(203) 469-8882
Fax (203) 467-9973

AUTHORIZATION TO RELEASE
AND/OR EXCHANGE INFORMATION

Today's Date_____

Patient's Name: _____ **Birth date:** _____
Parents / Legal Guardian: _____
Street Address: _____ **City:** _____ **Zip Code:** _____
Phone Number: _____

The undersigned, hereby authorize to release/disclose the above named individual's health information to

Release From:

East Haven Pediatrics PC
300 Main Street
East Haven, CT 06512
Telephone: (203) 469-8882
Fax: (203) 467-9973

Release to:

Name (Agency) _____

Address: _____

_____

Phone: _____

Fax: _____

Information to be released/disclosed

___ Entire Health Record
___ Office Visits/ Physical Exams
___ Reports (Labs, X-ray, etc)
___ Immunizations
___ Medications
___ Letters from specialists
___ Other _____

___ Psychiatric Information
___ HIV Related Records
___ Drug/Alcohol abuse History/ Treatment
___ Psychosocial Assessment/Developmental Tests/Records
___ Educational Records
___ Legal Information

Dates of treatment covered by this release: _____

Purpose
____ Continuity of Medical Care
____ At my request
____ School

____Other _____
____ Legal
____ not satisfied with medical care

Format: _X_ Only Paper at this time
Procedure: I would like my records mailed _____ Picked up _____

"I understand that the records released may contain information pertaining to psychiatric, drug and /or alcohol abuse treatment, and may also contain confidential HIV/AIDS related information."
"I understand that I may withdraw this consent at any time prior to the release of the above information."
"I understand that this consent will expire 180 days from the date below if not withdrawn."
"I understand that as a courtesy, East Haven Pediatrics PC will copy and send 1st set of their office generated medical records to my new provider at no charge, otherwise I agree to pay a fee of 0.65 cent per page/image." I also understand that I may pick up any received records from previous providers at no charge."
"I understand that according to the HIPAA Privacy Act (45C.F.R. §164.524 (b)(2)(i) , covered entities have 30 days to respond to my request."

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian Date
(if patient is under 18 years)

_____
Relationship to Child

_____
Signature of Witness Date

The information has been disclosed to you from the records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical records or other information is NOT sufficient for this purpose.

Rev 08/15/2013