Authorization for Access/Release of Information

Patient Name:_______________________________________ Date of Birth:__________________
SS#:_______-______-_______
Address:______________________________ City:____________________State:_________ Zip:_________
Phone: (D)________________(E)___________________

I hereby authorize Connecticut Kidney Center to :

☐ Release information from my medical record to: ☐ Obtain information from:

Name:___________________________________ Phone/fax:_________________________________
Address:_________________________________ ___City:______________State:________Zip:_________
Please note we will fax information directly to a ***physician's office only* (if this is not noted records will be mailed)

Information to be released or obtained as follows:

☐ Inspection only Dates of Service:_____________to:______________
☐ Copy of Standard Report Dates of Service:_____________to:______________
(Includes appropriate office notes, labs, procedure results)
☐ Copy of other Medical or Billing Information as specified: Dates of Service:_____________to:_____________
____
____

Purpose of Disclosure(must be noted):

☐ Changing of Physicians ☐ Consultation/second opinion ☐ Continuing Care
☐ School ☐ Legal:(specify)__________________ ☐ Insurance(other than payment)
☐ Other:________________ ☐ Social Security ☐ At Patient's Request

I understand that this authorization will expire one year after I have signed the form unless otherwise specified:_______________________
I understand that I may revoke this authorization at any time by notifying the providing organization in writing.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
I understand that I am not required to sign this form in order to receive treatment or payment for my care.
I understand that there may be a fee for a copy of my medical record.
I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67 and /or HIV/AIDS-related information in accordance with CGS19a-585(a), except as indicated below.

☐ No Mental Health ☐ No substance Abuse treatment information ☐ No HIV/AIDS

____ _______________
Signature of patient Date

____
Print Name

____ ________________ _______________________
Signature of Parent/Legal Guardian/Authorized Person Date Relationship to patient