AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient:	**DOB:**

I hereby authorize Barochia Internal Medicine to release/obtain all medical information with respect to the treatment of above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV related information.

Release the Medical Records From:

Method: ☐ Mail ☐ Pick up ☐ Fax

Medical Group Name:____________________________

Address:____
City:___________________ State:_____ Zip:________

Phone: _________________________
Fax:______________________

Send the Medical Records To:

Method: ☐ Mail ☐ Pick up ☐ Fax

Name:____

Address:_______________________________________
City:__________________ State:_____ Zip:_________

Phone:_________________________
Fax:______________________

What is the Purpose of Health Information Release:

☐ Personal	☐ New Physician	☐ Social Security	☐ Other:______________________
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	
☐ Consultation	☐ Workers Com	☐ Attorney	

Describe the Health Information to be Released:

Service Dates: from___________ to ___________ Information Needed By: ______________________________

☐ Complete Medical Record	☐ Other:______________________________		
☐ History and Physical	☐ EKG's	☐ Laboratory Results	☐ Hospital Notes
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Clinic Notes
☐ Hospital Discharge Summary	☐ Operative Reports	☐ Radiology Images	☐ Billing Information

I understand that Barochia Internal Medicine will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Barochia Internal Medicine. I understand that I may not be able to revoke this Authorization if Barochia Internal Medicine has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here:___________________

_________________________ ____
Date: **Signature of Patient or Person granting Authorization on behalf of patient**

____ ___________________________________
Print Name of Person Signing (If not the Patient) **Relationship to Patient**