136 Sherman Avenue – Lower Level Suite #6 • New Haven, Connecticut 06511
(Phone) 203-680-0030 (FAX) 860-331-8044

www.CTCtenterForPsychWellness.com

MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

By signing this form below, I authorize CT Center for Psychiatric Wellness to use, receive, release or disclose the below indicated protected health information. The patient or their representative may revoke this authorization by notifying in writing CCPW's designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. This Records Request/Release Form shall expire exactly one year from the signature date indicated below.

Person or Organization from whom records are being requested or to whom records should be released:

____

Purpose for use, release or disclosure of protected health information:

____

Protected Health Information to be sent to ***CCPW, 136 Sherman Ave LL #6, NH, CT 06511 – 860-331-8044 {Fax}***

- ☐ Copies of all medical records for the period of _____________to _________________
- ☐ Copies of the information described below for the period of _______________ to _________________
- ☐ Examination Reports
- ☐ Lab, X-Ray, ED, Etc. Reports
- ☐ Reports and records from other physicians
- ☐ Other: ____

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions of a sensitive nature.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to, or pick up from ***CT Center for Psychiatric Wellness..***

I am fully aware of my right under HIPAA regulations and have signed a copy of CCPW's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with CCPW's Privacy Compliance Officer and/or other appropriate management personnel.

I understand that CCPW assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release CCPW form all legal liability that may arise from the authorization.

Patient's Name:___________________________ Signature:______________________________ Date:_______

Patient's Date of Birth:____________________ Social Security Number:__________________________________

If Minor, Parent/Guardian Signature:____ Date:_____________