

MANCHESTER MEMORIAL HOSPITAL 71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL 31 Union Street, Vernon, CT 06066

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

No part of this authorization is a required field. However, it is requested to assist ECHN in fulfilling your request accurately. There may be a reasonable, cost-based fee that complies with both federal and state regulations, associated with this request.

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1. Patient Information		
NAME (Last, First, Middle Initial)		MAIDEN/OTHER NAME
DATE OF BIRTH	PREFERRED PHONE NUMBER ()	ARE YOU A VETERAN? YES NO
2. Release To/Obtain From	,	
I HEREBY AUTHORIZE ECHN TO:	Release Information TO Obtain Inform	nation FROM
NAME OF PERSON OR INSTITUTION	()	FAX NUMBER (Healthcare Providers Only ()
MAILING ADDRESS (Number/Street/A	partment No./PO Box) (City/Town)	(State) (Zip Code)
☐ Paper ☐ Electronically on CD/ METHOD OF DELIVERY ☐ Mail ☐ Verbal ☐	Pick-Up Onsite (Photo-ID Required) ☐ F	Fax (Healthcare Providers Only)
☐ By Unencrypted E-mail to This Email Add ** I am requesting my protected health inform releasing my medical record information usir	ress**: nation be delivered in an unencrypted format. I und ng unencrypted electronic formats, including access	Initial) lerstand and accept all risks associated with s by an unintended third party.
3. Information Request		
DATE(S) OF SERVICE FROM:	to	
TYPE OF INFORMATION TO BE RELEASED OR OBTAINED (Check One or More)		
☐ Emergency Department Record(s) ☐ Progress Note(s) ☐ PT/OT/Speech Note(s)		
History & Physical/Consult Record(s		Laboratory/Pathology Report(s)
Discharge Summary	☐ Imaging Report(s)	Patient Health Summary
Procedure/Operative Report(s)	□ EKG/Echo/Stress Test Result(s)	☐ Entire Record
Other Information (Please specify):		
If any of the above information being requested contains the following sensitive information, please initial. AIDS/HIV Information:		
	Denied Based On Providing This Information ☐ Other Healthcare Providers ☐ Support) ting a Claim/Appeal ☐ Legal ——
4. Authorization		
AUTHORIZATION EXPIRES (If no exp	iration given, authorization will expire twelve ((12) months from the signature date)
ONE (1) Year From Date of Authorization OR Other Date (Please Specify):/		
I hereby authorize Eastern Connecticut Health Network or its wholly owned affiliates (collectively "ECHN") to release,		
. I have the right to cancel (revoke) this au	bed above for such purposes described a thorization in writing to the respective Health Information frization can be found in ECHN's Notice of Privacy	nation Management Department or Privacy Officer
	n released or disclosed based upon this authorizati	
	ent at ECHN is in no way conditioned on whether o	
	a healthcare provider or health plan covered by	
disclosed as described above is no longe	r protected by the Privacy Rule and may be re-disc	losed by the recipient.
Patient Signature (Please let a Health In	formation Management Associate know if assis	stance is needed, or if unable to sign form)
Patient Print Name	Patient Signature	Date/Time
X	Х	X
Requestor Other Than Patient		
	n, please indicate the relationship of the re rity to act on behalf of the patient as checked althcare Representative	
Requestor Print Name	Requestor Signature	Date/Time
X	X	X

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PROHIBITIONS ON REDISCLOSURE NOTICE

AIDS OR HIV RELATED INFORMATION

In the event that information released constitutes confidential AIDS/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.

DRUG AND ALCOHOL ABUSE TREATMENT 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 and state confidentiality rules (42 CFR Part 2). The federal rule prohibits you from making any further disclosure of information in this record that identifies the patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31, 42 CFR Part 2). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

MENTAL HEALTH TREATMENT INFORMATION

In the event that the information released constitutes privileged psychiatric-patient communications: The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

STATEMENT OF NONDISCRIMINATION AND AVAILABILITY OF COMMUNICATION SERVICES

English: ECHN complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: if you speak English or any other language, language assistance services are available to you free of charge. Call 1-860-646-1222.

Español (Spanish): ECHN cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-646-1222.

<u>Polski (Polish)</u>: ECHN postepuje zgodnie z obowiazujacymi federalnymi prawami obywatelskimi i nie dopuszcza sie dyskryminacji ze wzgledu na rase, kolor skóry, pochodzenie, wiek, niepelnosprawnosc badz plec. UWAGA: Jezeli mówisz po polsku, mozesz skorzystac z bezplatnej pomocy jezykowej. Zadzwon pod numer 1-860-646-1222.

Copy to Medical Record Copy to Patient/Representative

