

Instructions: To Obtain a Copy of your Medical Records

Please complete and sign the 2-page "Authorization to Release Protected Health Information" form below. Include your full name, date of birth, current address, phone number, dates of service at New Milford Hospital and specify what information you want sent from your medical record. **Please be as specific as possible.** Complete page two of the form by writing your name on the top line and initialing the bottom, where designated.

The completed form can be returned or mailed to:

New Milford Hospital
HIM Department – Release of Information
21 Elm Street
New Milford, CT 06776

Please feel free to call the Health Information Management Department at (860) 350-7259 (press option 1), Monday – Friday, 8AM – 4PM, if you have any questions.



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record # _____

Address: _____

Date of Birth: _____ Telephone Number: _____ Identification Number: _____

Subject to the statements printed on the back. I, the undersigned patient, hereby authorize New Milford Hospital, or _____ to use my medical information, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related and psychiatric information ("Protected Health Information") for the purposes described below, and to obtain Protected Health Information from or released Protected Health Information to the following (list by name):

Name/Facility: _____

Address: _____

Telephone Number (if known): _____

The nature and extend of Protected Health Information to be used or disclosed: (Check applicable information)

INPATIENT Date of Discharge: _____

OUTPATIENT Visit Date: _____

- Discharge Summary # of Films
History & Physical
Consultation Reports
Clinical Progress Notes
Operative Report
Lab Reports:
Other:

- All Health Information # of Films
Emergency Dept. Record
Operative Reports
Pathology Reports
Lab Reports
Mammogram:
Other:

Limitations on Disclosure: _____

I understand that I am responsible for returning all original films back to New Milford Hospital and release New Milford Hospital from liability for the loss of any original films, which I have picked up by my signature below.

This Authorization and any information released under is are to be used for the following purpose(s) (Please describe purpose for which release authorized; such as legal proceeding, medical care, insurance, self, etc.).

I agree that a copy of this authorization will be as valid as an original. This authorization will be valid for a period of one year from the date below. I understand that I will have the right to revoke this authorization by notifying the Director of Health Information Management in writing, but this will not affect the information released prior to the withdrawal of my authorization. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulations.

I request revocation of this authorization on: _____ DATE SIGNATURE

I understand that my treatment or continued treatment by Provider is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign is.

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE) DATE PRINTED NAME

Unable to sign due to: _____

**Note if you are signing as the legal authorized representative of the patient, please indicate your relationship to the patient here (this should demonstrate your authority to consent to health care for the patient): _____

***** Office Use Only *****

Original films returned on: _____

Patient Name: _____

Any information released by New Milford Hospital to authorized persons is subject to the following notices:

Psychiatric Information:

In the event information released constitutes confidential psychiatric 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 further disclosure of it or using it for any purpose other than indicated on this authorization without the specific written consent of the person whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Record regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2).

The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-Related Information:

In the event that information released constitutes confidential 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.

PATIENT INITIALS