



The Saint Raphael Healthcare System
1450 Chapel Street, New Haven, CT 06511

Authorization Form for Disclosure/Release of Protected Health Information (PHI)
General Health Information/Drug/Alcohol/Psychiatric/HIV Related Information

Date: _____

Patient: _____ Date of Birth: _____ Medical Record#: _____

Address: _____ Telephone #: _____

1. I hereby authorize the Saint Raphael Healthcare System to: _____ Release _____ Receive information from the health record of the above named patient to:

Name of recipient: _____

Address of recipient: _____

2. The purpose for such information is: _____

3. Type of Service: _____ Inpatient _____ Outpatient _____ Emergency Room

4. Requested Data

- _____ All Records
- _____ Medical/Surgical abstract (summary)
- _____ Alcohol/Drug Related
- _____ Psychiatric/Psychosocial
- _____ Immunization
- _____ Physical Therapy
- _____ Other (specify): _____
- _____ Other (specify): _____

Specific Report(s) – check all that apply:

- Consultation
- Discharge Summary and Diagnosis
- Emergency Room Report
- EKG/EEG
- History & Physical
- Laboratory Report
- Operative Report
- Progress Notes
- Pathology Report
- Radiology: _____ Report _____ Films
- Other: _____

5. Approximate Date(s): _____

6. This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, drug and /or HIV or AIDS testing, diagnoses or treatment.

7. I understand there may be a 65-cent/per-page copy fee charged with certain requests for my health information. I have 30 days to receive a copy of my records unless otherwise specified. I understand my records may be located throughout the healthcare system and more than one authorization may be required to obtain all records.

8. I understand my right as stated in the Saint Raphael Healthcare System’s Notice of Privacy to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to the department that maintains my requested information. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire upon the earlier of 60 days from today’s date or a specific date, event, or condition to such revocation.

9. I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or copy the information to be used or disclosed according to state and federal law, and as stated in the Privacy Notice of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized redisclosure.

Signature of Patient or Legal Representative

If Legal Representative, specify relationship

The patient is a minor, _____ years of age

The patient is unable to authorize because: _____

Signature of Witness

Date

Notarized signature is required for patients requesting a copy of his/her medical record for personal use.

On this the _____ day of _____, 20____, before me, _____, the undersigned officer, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof I hereunto set my hand.

Signature Notary Public: _____

My Commission Expires: _____

Patients or legal representative requested this authorization be **revoked**. Do not comply with this request effective this date: _____. Recorded by SRHS staff (please print): _____.