YALE-NEW HAVEN HOSPITAL

Authorization for Access/Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____ - ____ - ____ (MO DAY YR) SS#: ____ - ____ - ____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize Yale-New Haven Hospital and related entities to:

❑ release information from my medical record to: ❑ obtain information from:

NAME: _____ PHONE/FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Please attach a separate sheet for additional recipients.

Send any obtained information to:

NAME: _____ PHONE/FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) as follows:

Dates of Service:

❑ Inspection Only _____

❑ Copy of Standard Report (includes, as appropriate, discharge summaries, operative notes, results of X-ray and lab tests and history and physical.) _____

❑ Copy of other Medical or Billing Information as specified:

_____ _____

_____ _____

PURPOSE OF DISCLOSURE:

❑ Changing physicians
❑ School
❑ Other (please specify): _____

❑ Consultation/second opinion
❑ Insurance (other than payment)
❑ Legal (please specify) _____

❑ Social Security
❑ Continuing Care
❑ At Patient's Request

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

❑ No Mental Health ❑ No Substance Abuse treatment information ❑ No HIV/AIDS

_____ _____
Signature of Patient Date

_____
Print Name

_____ _____
Parent/Legal Guardian/Authorized Person Date

_____
Relationship to patient

Please send completed form to:

Yale-New Haven Psychiatric Hospital
Medical Record Department-LV3
184 Liberty Street
New Haven, CT 06519

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING