Authorization for Release of Medical Information

Name of Patient _____ DOB _____

Please check appropriate request below:

_____ I authorize Connecticut Neuroscience, P.C. to **obtain** information **from** the physician/ organization named below. All pertinent parts of the medical records on the above-named patient, including information relating to the diagnosis or treatment of psychiatric illness, drug or alcohol abuse, and/or confidential HIV-related information are to be included.

_____ I authorize Connecticut Neuroscience, P.C. to **release** medical information to the physician/ organization named below. All pertinent parts of the medical records on the above-named patient, including information relating to the diagnosis or treatment of psychiatric illness, drug or alcohol abuse, and/or confidential HIV-related information are to be included. We require 10 days notice for release of records.

Physician/Organization Name: _____

Address: _____

City, State, Zip Code: _____

_____ _____

Date **Signature of patient or person legally authorized to sign on behalf of patient**

If this form has not been signed by the patient, please state the signer's name and relationship to the patient, and if necessary, explain why the patient did not sign.

NOTICE OF RIGHTS AND CONFIDENTIALITY REQUIREMENTS

The refusal of the patient (or person authorized to sign for the patient) to authorize the release of information will not jeopardize the patient's right to obtain present and future treatment except where disclosure is necessary for such treatment. However, a hospital/health care provider may be required by law to disclose information from the medical record to certain individuals or entities despite the refusal to authorize such disclosure.

The confidentiality of information in the medical records is required by Connecticut and/or federal law, especially information representing communications between psychiatrist and patient, the diagnosis or treatment for alcohol or drug abuse, and/or HIV-related information. The information disclosed pursuant to this authorization may not be further disclosed without the written consent of the patient or his authorized representative. A general authorization will not be sufficient for any further disclosure of information related to mental illness, alcohol or drug abuse, or HIV-related information, and may not be sufficient for the disclosure of any other information.

Purpose for Release of Records: (please indicate below)

Transfer to new MD ____ Legal Investigation ____ Moving ____ Worker's Compensation ____

Change of Insurance ____ Disability Determination ____ Other ____ Staff/physician issues ____