Fairfield County Integrative Family Medicine, LLC

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____Date of Birth: _____

Parent's Name (if patient a minor):_____ _____Telephone# _____

Patient's Address: _____

I hereby authorize the release of my medical records from: _____

I hereby authorize the release of my medical records to: _____

I hereby authorize the individual/entity listed above to release my own or my child's records described above, including AIDS/HIV, psychiatric, drug abuse and/or alcohol related information if applicable and use of the information for the purpose of:

☐ At the request of the patient

☐ Other: _____

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 mental health/psychiatric information, alcohol, drug and/or HIV or AIDS testing, diagnoses and treatment.

I understand that it is my right as stated in the Fairfield County Integrative Family Medicine, LLC (FCIFM) 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 FCIFM. I understand this revocation will not apply to the information that has already been released in response to this authorization.

I understand authorizing this 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/copy the information to be used or disclosed according to state and federal law, and as stated in the Notice of Privacy of FCIFM. I understand information once released from this office may not be protected by HIPAA rules and carries with it the potential for an unauthorized re-disclosure.

_____ _____
Signature of Patient or Legal Representative If Legal Representative, specify relationship

_____
Name- Please Print

_____
Date

_____
Recorded/witnessed by FCIFM Staff

Fairfield County Integrative Family Medicine, LLC
324 Elm Street, Suite 203A
Monroe, CT 06468
Phone (203) 445-9060, Fax (203) 445-9093