AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Medical Records Fax: 203-730-4166

107 Newtown Rd, Danbury CT 06810

Privacy Officer: Jennifer Retter

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. It may be invalid if not fully completed. Please note record requests are now processed through the patient portal at no charge. If you need paper copies of your records printed there is a 0.65 cent per page fee, per section 20-7c of the Connecticut statute.

Patient Name authorizing ASC to disclose health information

_____

Please check specialty & provider records needed.

☐ Ear Nose & Throat Care MD:_____ ☐ Dermatology MD:_____

☐ Plastic Surgery MD:_____ ☐ General Surgery

☐ Allergy&Asthma MD:_____ ☐ Audiology Provider:_____

☐ Test Results Only -- Type:_____

Please list specific types of health information to be disclosed:

_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.

☐ **I authorize Advanced Specialty Care to obtain my medical records FROM:**

Name: _____ Address: _____ Fax: _____

☐ **I authorize Advanced Specialty Care records to send my medical records TO** (for a fee of 0.65 cents per page, we will inform you of total fee due prior to records being sent):

Name: _____ Address: _____ Fax: _____

☐ **I authorize Advanced Specialty Care to send my records electronically TO my portal account at no charge**

If you are not currently enrolled on the portal please call ext. 8720.

Reason for Request: _____

Effect of Refusal to Sign Authorization

I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

This authorization is effective indefinitely unless revoked in writing.

I understand that I have the right to receive a copy of this authorization

Signed: _____ Print Name: _____ Date: _____

Patient Name: _____ Patient DOB: _____