Name:
Chart:
Age:
Date:

SHAREDID-5

OrthoConnecticut
World-class care, close to home.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

Revocation
Date Revoked: _____
Initials of Privacy Official:

Patient's Name (First, Middle, Last)	Date of Birth	Social Security No.	
Patient's Address	City	State	Zip
Home Phone with Area Code	Cell Phone No.		

1. **Type of Information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated): _____ to _____

_____ The entire medical record (all information)
_____ Diagnostic reports (lab, x-ray, etc.)
_____ Medication and treatment records
_____ Other: (Describe as specifically as possible)
_____ Physician and professional consult progress notes
_____ Physician's orders

☐ Picked up by: _____

☐ Location: _____

☐ Mail: _____

☐ Fax: _____

2. **Recipient of information -** The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____
Address: _____ Address: _____

Name: _____ Name: _____
Address: _____ Address: _____

Name:
Chart:
Age:
Date:

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION - page 2

3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

_____ Initiated at the request of the patient. _____ Sharing with other health care providers as needed

_____ My personal records _____ Other (please describe): _____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed OrthoConnecticut staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. Unless I specify differently, this authorization will expire (insert date or event):

_____

7. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

8. **Charges:** I further understand that OrthoConnecticut, in accordance with Connecticut State Law, may charge up to 65 cents per page. I agree to pay these charges plus any postage.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Distribution of copies: Original to patient's Medical Record, copy to patient.