Patient Directed Release of Records
DIRECTLY TO PATIENT OR TO A DESIGNATED PERSON

New England Pediatrics

PATIENT NAME _____ PATIENT DATE OF BIRTH _____

PATIENT HOME ADDRESS _____
(for verification):

PATIENT PHONE NUMBER _____
(in case we have questions)

I hereby request a copy of my medical and billing records, as contained in the designated record set of New England Pediatrics, LLP ("Practice"), be made available to me, or a copy provided, consistent with my wishes below. I understand there may be a charge for the copy, which can include the labor costs of preparing the copy, supplies, electronic media, and postage.

SECTION 1. SCOPE AND FORMAT OF RECORDS REQUESTED.

☐ MY ENTIRE RECORD. ☐ ONLY A PORTION OF MY RECORDS (DESCRIBED BELOW):

_____

By checking "My entire record" I authorize New England Pediatrics, LLP to release my complete medical health records including a copy of my complete and entire mental health record, all records for my care and treatment, including psychiatric and drug information, and information regarding HIV/AIDS status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, films, all consent forms and billing information.

If any of the information to be released constitutes a psychiatric communication or communication with a psychologist, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes may be disclosed by my signing this authorization, and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release found in Part 2 of Title 42 of the C.F.R., which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

THE FORMAT OF THE COPY I WISH SENT IS: _____
The format may be paper, electronic or mixed, depending both on how it is maintained, and on your copy format preferences. Please check with our staff to discuss the options available for paper and/or electronic copies.

SECTION 2. FOR RECORDS GOING DIRECTLY TO THE PATIENT. (CHOOSE ONE)

☐ I WISH THE COPY SENT TO ME AT THIS ADDRESS: _____
The address may be a street address for mailing or an electronic address if the record is being transmitted electronically.

☐ I WILL PICK UP THE COPY IN PERSON.

☐ I WISH TO INSPECT THE RECORD. *(We will arrange a mutually agreeable time for the record inspection.)*

SECTION 3. FOR RECORDS GOING DIRECTLY TO SOMEONE OTHER THAN THE PATIENT.
Use this portion only if the patient wants a copy of records sent to directly someone else.

☐ I DIRECT YOU TO SEND A COPY OF MY RECORDS, AS SET FORTH IN SECTION 1 ABOVE, TO ANOTHER PERSON, WHOSE NAME AND ADDRESS I HAVE LISTED BELOW.

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of New England Pediatrics, LLP.
I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that there may be medical records from another doctor or another medical facility in the patient's medical record.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

_____
NAME OF PERSON WHO WILL RECEIVE RECORDS:

_____
ADDRESS OF PERSON WHO WILL RECEIVE RECORDS:
The address may be a street address for mailing or an electronic address if the record is being transmitted electronically.

SECTION 4. PATIENT SIGNATURE REQUIRED.

_____
SIGNATURE OF PATIENT/CLIENT, *or his/her authorized representative, or parent or guardian if a minor, please specify relationship to patient/client.* **DATE**

_____
IF A REPRESENTATIVE SIGNS, DESCRIBE THE REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT:

Please see the reverse side of this form for specific disclosure information regarding mental health, drug and/or alcohol abuse and HIV related information.

Rosemary Klenk, MD • Alan Morelli, MD • Todd Palker, MD • Jason Davis, MD • Elizabeth Cipolla, MD • Gretchen Crist, MD

NEW CANAAN • 183 Cherry St., 06840 • 203.972.5232 • FAX 203.972.5234 • STAMFORD • 31 Strawberry Hill Ave.,06902 • 203.323.1770 • FAX 203.348.1501 • www.nepeds.com

TO THE RECIPIENT OF THESE MATERIALS

HIV/AIDS INFORMATION: In the event that any of the disclosed information includes HIV/AIDs information, this is protected under state law as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Any oral disclosure shall by accompanied or followed by the above notice. *See Connecticut General Statute section 19a-585.*

PSYCHIATRIC COMMUNICATIONS: If the released material contains confidential psychiatric communication, as designated in C.G.S. sections 52-146d through 52-146i, inclusive, please note the following:

> "The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes." A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and\or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and\or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." See *Connecticut General Statute section 17a-688.*