PACT Physicians Alliance of Connecticut | Hartford HealthCare

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Demographics		
	Patient Name	Date of Birth
	Phone #	Last 4 digits of SSN
	Address	

Release/Obtain My Information			
	I hereby authorize Physicians Alliance of Connecticut, LLC (PACT) and/or its divisions to use or disclose my health information as follows:		
	to Me	Address if different from above otherwise write SAME	
	to a Third Party	Name:	
		Address:	
		Phone:	Fax:
	from Another Provider	Name:	
		Address:	
		Phone:	Fax:

Information to Release/Obtain

☐ Complete Medical Record
[**NOTE**: checking this box *does not* include HIV/AIDS, Psych/Mental Health and/ or Alcohol/Drug related information – you must separately check each of those boxes below]

☐ Procedure/Surgical Reports	☐ Laboratory/Pathology Reports
☐ History & Physical	☐ ECHO (Cardio) Tapes/Results
☐ Consultation Reports	☐ Radiology Reports
☐ Progress Notes	☐ Discharge Summary
☐ Billing Records	☐ Telephone Messages
☐ Other (please specify):	

Additionally, I specifically authorize the release of the following sensitive information.
(Check only if you agree)

☐ HIV/AIDS related information	☐ Psychiatric Records/Mental Health
☐ Alcohol and/or Drug Abuse Records	

If you want us to release only limited ***sensitive*** information based on one of the three sensitive information categories, please indicate so here:

Dates of Service	Limit the release to specific dates or indicate all records
	☐ All records up to today
	☐ Records from: _____ to _____

Purpose of Request	Purpose of the requested use or disclosure (information will be used for)
	☐ Patient/Representative Use ***or***
	☐ Other (please specify):

Manner of Transmission	I am requesting that the records identified above be handled in the following manner (Identification verification may be required):	
	☐ Mail to Address Listed Above	☐ I will pick-up
	☐ Fax Number/Attn:	
	☐ A *Representative* will pick-up on my behalf (name of *Representative*):	
	☐ Other:	

Expiration	This authorization is valid for ninety (90) days from the date it is signed unless revoked or an alternative expiration date is provided here:	Initials

Individual Rights	
	I may refuse to sign this Authorization;
	I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to the Medical Records Department of the applicable PACT facility;
	My revocation will be effective upon receipt, however, I understand that this revocation will not apply to information that has already been released in response to this authorization;
	I have a right to receive a copy of this authorization;
	I may inspect or obtain a copy of the health information that I am being asked to use or disclose;
	Neither treatment nor payment will be conditioned on me signing this authorization;
	If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

By signing below, I acknowledge that I have read and understand this authorization form and that PACT has 30 days to fulfill my request.

_____

Signature Patient/Patient Representative Date

_____

(Relationship If Signed by other than Patient. Proof required for legally appointed representatives)