Unionville Pediatrics
P.O. Box 221 Unionville, CT 06085

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Phone: (860) 673-6124

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize _____to disclose or obtain health information, including if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name: _____

Birth date: _____/_____/_____

Phone: (_____)_____

The dates of service and the type(s) of information to be used or disclosed is as follows:
Date(s) of Service: _____ ☐ Inpatient ☐ Outpatient ☐ Emergency Visit

Information may be ☐ Disclosed to ☐ Obtained from
Other Facility Name/Facility: _____
Mailing Address: _____
City/State/Zip: _____
Phone: (_____)_____ ☐ Hand-Carry ☐ Fax to: (_____)_____

The purpose of this disclosure or use is for the following reason:
☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ At the request of the patient or legal representative
☐ Other(please specify):_____

Requested Information:
☐ Complete Record
☐ Abstract Only: Please specify if you need specific reports only: ☐ History & Physical ☐ Laboratory Report ☐ Discharge Summary ☐ X-Ray Report ☐ Operative Reports
☐ Consultations ☐ EKG Report ☐ X-Ray Films ☐ Billing Statement
☐ Other(please specify):_____

I understand that my treatment or continued treatment by _____ is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.
This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying Unionville Pediatrics in writing, but if I do it will not have any effect on actions that the releasee took before it received the cancellation. Please be advised that this is the policy of Unionville Pediatrics that once your complete medical records are released to a NEW PHYSICIAN, we will not be able to accept your return to our practice.

Signature of Patient or Legal Representative: _____
Printed Name: _____ **Date:_____/_____/_____**
If not patient, state the relationship to patient below (legal documentation required as applicable):
☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other:_____