Authorization for Access/Release of Information

Patient Name (Last, First, MI) ____

Date of Birth: ________________ Medical Record Number_______________

Address:_________________________________ City/State:__________ Zip:______

Day Phone:__________________ Evening Phone:___________________

I hereby authorize Connecticut Pediatric Otolaryngology and related entities to:

___ release information from my medical record to: ___Obtain information from:

Name:___________________________________ Phone/fax:__________________

Address:_________________________________ City/State:__________ Zip:______

___ Inspection Only

INFORMATION TO BE RELEASED OBTAINED (VERBAL OR WRITTEN FORM) AS FOLLOWS:

Dates of Service:_________________________

___ Copy of Standard Report (includes, as appropriate, discharge summaries, operative notes, results of X-ray and lab tests and history and physical)

___ Copy of other Medical or Billing Information as specified: __________________________

Purpose of disclosure:

___changing physicians ___second opinion ___social security ___school

___continuing care ___insurance ___legal ___pt request

___other _____________________

- I understand that this authorization will expire one year after I have signed the form or other time frame as specified: _____________________________
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no lo0nger be protected by privacy regulations.
- I understand that I am not required to sign this form in order to receive treatment or payment for my care.
- I understand that there may be a fee for a copy of my medical record.

____ __________
Signature of Parent/Legal guardian/authorized person Date

____________________________________ ____________________
Print Name Relationship to patient