

**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 longer 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