FVOA

FARMINGTON VALLEY ORTHOPEDIC ASSOCIATES, P.C.

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Medical Records Release

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning

____

(Patient name) (Address)

Description of health information to be used or disclosed: □ **X-Ray** □ **Office Notes**

This health information may be disclosed to and used by: □ **Self**

□ Other____

(Name and address of person/entity to receive and use the health information)

The information may be used and disclosed only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

□ At the request of the individual or Other purpose_________________________

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric Disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed.
I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.
I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

This authorization is effective now and will remain in effect until _______________________

(Expiration event or date).

I understand that I have the right to receive a copy of this authorization.

Print Name: __________________________ Signature/Date: ______________________

If not signed by the patient, please indicate relationship: __________________________