# AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

**PLEASE RETURN REQUEST TO:**

**Mail:** Nuvance Health
The Summit
Attn: Health Information Management
100 Reserve Road
Danbury, CT 06810
**Fax:** (203) 749-9000
**Email:** medicalrecords@nuvancehealth.org
**Phone:** (203) 739-7218
****Record pick-up not available at The Summit, Danbury Hospital, or New Milford Hospital. See page 2 for alternate pick-up locations.**

**LOCATION**

☐ Danbury Hospital ☐ Putnam Hospital ☐ Vassar Brothers MC
☐ New Milford Hospital ☐ Sharon Hospital
☐ Northern Dutchess Hospital ☐ The Heart Center
☐ Norwalk Hospital ☐ The Thompson House
☐ Nuvance Health Medical Practices: Office/Dr. ___________________________
Medical Practice State: ☐ Connecticut ☐ New York

**PATIENT INFORMATION**

Patient Name: ______________________________ Date of Birth: _______ /_______ /________

Address: ______________________________ Town:____________________ State:______ Zip Code:__________

Phone Number:(______) _______________ *If patient is a minor, do they reside with their parent(s)? ☐ YES ☐ NO

**REQUESTER INFORMATION**

I hereby authorize Nuvance Health to disclose the records described below to the following person or organization I have specified in this section.

Name: ______________________________ Phone Number:(_______)________________

Address: ______________________________ Town:____________________ State:______ Zip Code:__________

Email:______________________________ Fax Number:(________)________________
*For Hospitals and Medical Offices Only

**Purpose:** ☐ Continuing Care ☐ Legal ☐ Disability ☐ Insurance ☐ Worker's Comp ☐ Verbal Discussion ☐ Personal

**INFORMATION TO RELEASE**

**Date(s) of Service:** *From*:_______________ *To*:_________________

☐ Abstract of Record (summary)
☐ Complete Record
☐ Emergency Room Record
☐ Office Visit Notes
☐ History & Physical Report
☐ Discharge Summary
☐ Operative/Procedure Report
☐ Laboratory/Pathology Report
☐ Radiology Report
☐ Radiology CD
☐ Medication/Vaccine Record
☐ Billing Statements
☐ Physical/Occ/Speech Therapy
☐ Other:____________________

***If records contain any of the following sensitive information, please place your initials where indicated in this section that you specifically authorize release of these sensitive records.**

- Drug/Alcohol Abuse (***INITIAL:***______)
- Mental Health (***INITIAL:***______)
- HIV/AIDS-STD (***INITIAL:***______)
- Genetic Testing (***INITIAL:***______)
- Reproductive Health Care Services (***INITIAL:***______)

**FORMAT** ☐ Paper ☐ CD ☐ Electronic

**DELIVERY METHOD** ☐ Pick-up ☐ Mail ☐ Fax ☐ Secure Electronic Delivery (email)

In accordance with state and federal laws, 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 is no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as genetic testing information, substance abuse treatment information, HIV/AIDS-related information, psychiatric/mental health information and reproductive health care information. I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future psychiatric treatment except where disclosure of the communication and records is necessary for treatment. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment or eligibility for benefits. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already taken in reliance on the authorization. The revocation letter should be sent to the Health Information Management department at the Nuvance Health location listed above.
This authorization will expire on ______/______/______. If no expiration date is specified, authorization will expire 12 (twelve) months from date of signature. By signing below, I acknowledge that I have read and understand this authorization form.

______________________________________________ ______________________________
**Signature of Patient or Authorized Representative (Guardian/Agent/Surrogate)** **Date**

______________________________________________ ______________________________
**Printed Name of Authorized Representative** **Relationship to Patient/Authority to Act on their Behalf**

If signed by the Patient's Representative, specify the relationship to the patient and authority to act on their behalf. If the patient is a minor (under 18) or has a legal guardian, in most cases, the patient's parent or legal guardian must sign this authorization. A copy of the legal documentation must be provided. If a minor patient is receiving treatment for psychiatric conditions, drug/alcohol abuse, sexually transmitted disease (STD) or HIV/AIDS, genetic testing, and reproductive health care services the minor's consent may be required for disclosure of records. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain their authorization.

**RECORD PICK-UP LOCATIONS:** Visit the Health Information Management (Medical Records) Department at the following locations to obtain your Nuvance medical records. These locations can access records for both CT and NY Nuvance hospitals and medical practices upon request.

-Norwalk Hospital: HIM Department is located at 333 Post Road West, Westport, CT
-Northern Dutchess Hospital: Rhinebeck, NY
-Putnam Hospital: Carmel, NY
-Sharon Hospital: Sharon, CT
-Vassar Brothers Medical Center: Poughkeepsie, NY

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## ABSTRACT OF RECORD & COMPLETE RECORD DEFINITION FOR ACUTE CARE RECORDS

- **Abstract of Record:**
  This is a partial set of records from the patient's encounter. This set consists of Emergency Department Provider and nursing notes, History & Physical, Consults, Operative/Procedure Reports, Discharge Summary, and diagnostic testing reports.
- **Complete Record:**
  This is the full set of records containing all documentation during the patient's encounter. This set consists of Emergency Department Provider and Nursing notes, History & Physical, Consults, Progress Notes, Operative/Procedure Reports, Discharge Summary, Diagnostic testing reports, Medication Administration Records, Pre and Post-Operative Care, Consents, Discharge Instructions, Ambulance Run Sheet, and all documents created during the encounter.

## ABSTRACT OF RECORD FOR MEDICAL PRACTICE RECORDS

- Abstract of record from medical practice consists of the Office Visit Notes and diagnostic test reports.

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## NOTICE & PROHIBITIONS ON REDISCLOSURE

**Minors:**
If a minor has the authority to consent to a particular health care service without parental or other consent, or if the parent or guardian has agreed to confidentiality between the provider and the minor, the minor has sole authority to exercise his or her rights under HIPAA. For example, under appropriate circumstances, minors may consent to their own HIV testing and treatment, treatment for alcohol and drug abuse, outpatient mental health treatment, or treatment of sexually transmitted diseases without parental consent. In cases where the minor provides his or her consent, parents and others will not be recognized as personal representatives and so will not have access to the minor patient's protected health information (PHI) related to the treatment.

**Psychiatric Records and Communications:**
If the information released constitutes confidential psychiatric information protected under **Connecticut** Law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

If the information released constitutes clinical records protected under **New York** Mental Hygiene Law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without specific written consent by the person to whom it pertains, or as otherwise permitted by law.

**Drug and Alcohol Abuse Records:**
If the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**HIV/AIDS-Related Information:**
If the information released constitutes confidential HIV-related information protected under **Connecticut** law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

If the information released constitutes confidential HIV-related information protected under **New York** law:
This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of Medical or other information is NOT sufficient authorization for further disclosure.

If you experience discrimination because of the release or disclosure of HIV/AIDS-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

**Reproductive Health Care Services (Connecticut):**
Information regarding the provision and receipt of reproductive health care services is protected under Connecticut law (Public Act No. 22-19). "Reproductive health care services" include all medical, surgical, counseling, or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception, or the termination of a pregnancy. State law prohibits the disclosure of any communication about reproductive health services from a patient or the patient's relating conservator, guardian, or other authorized legal representatives, or any information obtained by a personal examination of the patient relating to reproductive health services, without the written consent of the person to whom it pertains, except in limited circumstances as outlined in the law. As the patient, or the patient's conservator, guardian, or other authorized legal representatives, you have the right to withhold such written consent.