Bristol Primary Care LLC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: **DOB:**

I hereby authorize Bristol Primary Care LLC to release/obtain all medical information with respect to the treatment of above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV related information.

Release the Medical Records From:

Method: ☐ Mail ☐ Pick up ☐ Fax

Medical Group Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: _____

Fax:_____

Send the Medical Records To:

Method: ☐ Mail ☐ Pick up ☐ Fax

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Fax:_____

What is the Purpose of Health Information Release:

☐ Personal	☐ New Physician	☐ Social Security	☐ Other:_____
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	
☐ Consultation	☐ Workers Com	☐ Attorney	

Describe the Health Information to be Released:

Service Dates: from_____ to _____ Information Needed By: _____

☐ Complete Medical Record	☐ Other:_____		
☐ History and Physical	☐ EKG's	☐ Laboratory Results	☐ Hospital Notes
☐ Immunization Records	☐ Pathology Reports	☐ Radiology Reports	☐ Clinic Notes
☐ Hospital Discharge Summary	☐ Operative Reports	☐ Radiology Images	☐ Billing Information

I understand that Bristol Primary Care LLC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Bristol Primary Care LLC. I understand that I may not be able to revoke this Authorization if Bristol Primary Care LLC has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.
I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here:_____

_____ _____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

_____ _____

Print Name of Person Signing (If not the Patient) **Relationship to Patient**