



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION



I am requesting my protected health information (PHI) from:

- Johnson Memorial Hospital Saint Francis Hospital
- Mount Sinai Rehabilitation Hospital Saint Mary's Hospital
- Mercy Medical Center

Trinity Health Of New England Medical Group – CT: (specify below)

Other _____
PRACTICE NAME MEDICAL PROVIDER NAME

PATIENT INFORMATION

Patient Full Name: _____ Date of Birth: ____ / ____ / ____

Other Names During Treatment? _____ Phone #: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

RELEASE INFORMATION TO

Name / Facility: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____

Purpose of Request: Personal Treatment Legal Insurance Disability
 Transfer / Reason: _____ Other: _____

Delivery Method: US Mail Email In-Person (Pick-up) MyChart Fax CD

A cost-based fee will be applied for all copies released directly to patient or authorized legal representative. The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

INFORMATION TO BE RELEASED

I authorize the following PHI to be released from my medical records:

- Dates of Service to be released: From: ____ / ____ / ____ To: ____ / ____ / ____
- Abstract/ Pertinent Information ER Record History & Physical Operative/ Procedure Report Other _____
- Consultations Face Sheet/ Demographic Sheet Itemized Billing Record Pathology Reports
- EKG/ECG/Cardiac Tests Lab Reports MD Progress Notes Radiology Images
- Entire Medical Record Discharge Instructions Discharge Summary Medication Records Radiology Reports

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

***Required** – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

- Check one Initial each line below
- I DO DO NOT want information about ***Mental Health** released _____
 - I DO DO NOT want information about ***HIV Tests & Related Information** released _____
 - I DO DO NOT want information about ***Alcohol and/or Substance Abuse** released _____
 - I DO DO NOT want information about ***Reproductive Healthcare Services** released _____
 - I DO DO NOT want information about ***Genetic Testing** released _____
 - I DO DO NOT want information about ***Sexually Transmitted / Venereal Diseases** released _____
 - I DO DO NOT want information about * _____ released _____

STOP Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if the protected information is not checked and initialed, we may be unable to fulfill this request.

Patient's Signature: _____ Date: _____
(Required for all patients 18 years and older. 16 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian: _____ Date: _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 180 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation. I understand that under the applicable law the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by Trinity Health Of New England and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. I understand that I may inspect or copy the information that is used or disclosed.



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Trinity Health Of New England Health Information Management Department (formerly, Medical Records) is dedicated to processing your request or inquiry for protected health information in a timely manner. To aid us in fulfilling your request or inquiry please review the listing of frequently asked questions on our company's website at www.trinityhealthofne.org. The Health Information Management hours of operation are Monday through Friday, 8:00 a.m. to 4:30 p.m. and we can be reached at 860-714-4646.

Trinity Health Of New England contracts with MRO (Medical Records Online) Corporation to copy and release medical records. Federal law permits Trinity Health Of New England to charge a reasonable cost-based fee for copies of medical records (reference 45 CFR § 164.524(c)(4)). Federal Law also provides a health care facility 30 calendar days to process a request for medical records. Trinity Health Of New England will aim to process your request within 10-15 business days, depending on the type of records, dates of service requested, and payment of request.

To obtain copies of your record, mail or fax the completed authorization form to one of the Following:

Mail to:

ATTN: Health Information Management
Trinity Health Of New England
114 Woodland Street
Hartford CT, 06105

Fax to:

1 (610) 879-9041

Email to:

Records@trinityhealthofne.org

To follow-up on a status of your request, please call 610-994-7500.