WILLOWS PEDIATRIC GROUP

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I hereby authorize Willows Pediatric Group to release my medical health records including a copy of my complete and entire mental health record, all records for my care and treatment, including psychiatric and drug information, and information regarding HIV/AIDs status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports.

I understand that no psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations, which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

The records to be used/disclosed consist of: (Note: This description must be specific and meaningful. If all records are being authorized for release, "entire record" should be stated.)

_____

_____

Please check reason for transfer:

__ Family Relocation
__ Transfer to Adult Physician
__ Change of Insurance (Which Insurance? _____)
__ Other (please explain) _____

_____

RELEASE /SEND TO:

Address:_____

_____

_____

_____

Fax Number (if immunizations are being sent ahead):

_____

		(Date of Birth)	(Signature *)
Child(s) Name	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

(*PLEASE NOTE: As part of the HIPAA regulations, any child 13 yrs or older must sign for themselves.)

Requests take up to 30 days to complete but are often completed sooner. If you have any questions about your request, please call ext. 1246 and leave a message. Requests are completed in the order that they are received. If you would like your child's immunization records sent ahead of the full records, this can be done within a few days of receiving your request. Please note this on the front of the form.

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

Signature:_____Print Name:_____
Date:_____ Relationship to Patient: _____

This authorization expires:_____

If a representative signs, describe the representative's authority to act on behalf of the patient:
_____

PLEASE NOTE: We must ask you to show ID if you are picking up your records. If someone other than the parent/responsible party picks up records they will be required to present written permission to do so from the parent/responsible party.

PLEASE SEE THE FOLLOWING PAGE OF THIS FORM FOR SPECIAL DISCLOSURE INFORMATION REGARDING MENTAL HEALTH, DRUG AND/OR ALCOHOL ABUSE, AND HIV-RELATED INFORMATION.

WILLOWS PEDIATRIC GROUP
1563 POST ROAD EAST
WESTPORT, CT 06880
203-319-3939

TO THE RECIPIENT OF THESE MATERIALS:

HIV/AIDS INFORMATION: In the event that any of the disclosed information includes HIV/AIDS information, this is protected under state law as follows:

> "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." Any oral disclosure shall by accompanied or followed by the above notice. See Connecticut General Statue section 19a-585

PSYCHIATRIC COMMUNICATIONS: If the released material contains confidential psychiatric communication, as designated in C.G.S sections 52-146d through 52-146i, inclusive, please note the following:

> "The confidentiality of this record is required under Chapter 899 of the Connecticut general statues. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues" A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and/or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and/or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R 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." See Connecticut General Statute section 17a-688.

(Revised and Updated 1/2016)