

# Authorization for Release of Information

Yale Medicine

Yale  
NewHaven  
Health

**Patient Legal Name:** \_\_\_\_\_  
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

**Date of Birth:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_  
(po box # or street, city, state, zip code)

**This information is to be used for purpose of:**  Personal use  Continuing care  Legal  Disability  Workers Comp  
 Insurance Eligibility/Benefits  Social Security Claim  Veterans Benefits  Other \_\_\_\_\_

### Release information from my medical record to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Delivery Method: (Choose one only)  
 MyChart patient portal (Must have active account. To activate your account go to mychart.ynhhs.com)  
 Mail  Fax (Please enter the fax number): \_\_\_\_\_  
 Secure Email: \_\_\_\_\_  Pick Up/Hand Carry

### Location of Services: (Check all that apply)

Hospital  
 YNH - York Street Campus  YNH - St. Raphael's Campus  Smilow Cancer Hospital / Outpatient Locations  
 Greenwich Hospital  Bridgeport Hospital  Bridgeport Hospital - Milford Campus  
Outpatient Provider Clinic/Practice Name  
 Yale Medicine (YM) \_\_\_\_\_  
 Northeast Medical Group (NEMG) \_\_\_\_\_  
 Health At Home/VNASC Location: \_\_\_\_\_  
 Yale New Haven Urgent Care Location: \_\_\_\_\_  
 Physician One Location: \_\_\_\_\_

### Medical Information Requested:

**Date of Service(s):** \_\_\_\_\_ **Or Date Range From:** \_\_\_\_\_ **To:** \_\_\_\_\_  
 Hospital Admission Abstract (Includes: History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)  
 Outpatient Visit Notes  History & Physical Exam/HP  Stress Test  Consult Report  
 Discharge Summary/DS  Lab Results  Echocardiogram/EKG  Immunization Record  
 Emergency Visits/ED  Radiology Report  Pulmonary Function Test  Medication List  
 Operative/Procedure Report  Pathology Report  PT/OT/Speech Notes  Other: \_\_\_\_\_  
 Complete Medical Record (Excludes data collection flowsheets unless specifically requested).  Include Flowsheets  
*Items requested below will be sent separate from medical records:*  
Radiology Images:  CT  MRI  Ultrasound  X-Ray  Other: \_\_\_\_\_  
 Itemized Bill



**SENSITIVE INFORMATION:** All information selected on page 1 will be disclosed with this authorization unless specifically requested to be excluded as indicated below. Please do NOT include the following information:

- HIV/AIDS    Behavioral Health/Mental Health    Substance Use (Alcohol/Drug Treatment)    Termination of Pregnancy  
 Sexually Transmitted Disease    Genetic Testing    Other: \_\_\_\_\_

**I understand that:**

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing YNHHS Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. 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.
- That this authorization is voluntary and my treatment by YNHHS/Yale Medicine is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol information is included, the minor must sign as described above.

**\*\*\* Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV/AIDS, substance use (alcohol/drug treatment), termination of pregnancy, and/or sexually transmitted disease). For behavioral health/mental health, the patient if a minor age 16 or older is also required to authorize release of medical records.**

**Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.**

**Mailing Address:   Yale New Haven Health  
Health Information Management  
Release of Information Services  
PO Box 9565  
New Haven, CT 06535**

<b>YNHHS Hospital(s) Fax Number:</b>	<b>203-688-4645</b>	<b>Email to: <a href="mailto:releaseofinfo-Hosp@ynhh.org">releaseofinfo-Hosp@ynhh.org</a></b>
<b>NEMG Provider Fax Number:</b>	<b>203-200-1286</b>	<b>Email to: <a href="mailto:releaseofinfo-NEMG@ynhh.org">releaseofinfo-NEMG@ynhh.org</a></b>
<b>YM Provider Fax Number:</b>	<b>203-200-1287</b>	<b>Email to: <a href="mailto:releaseofinfo-YM@ynhh.org">releaseofinfo-YM@ynhh.org</a></b>

**Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 203-688-2231.**

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**  
*\*\*must provide proof of authority (except parent of a minor)*

**Please check relationship to patient**

- Self    Parent    Legal Guardian    Executor/Administrator of Estate    Healthcare Representative    Conservator  
 Other Authorized Legal Representative \_\_\_\_\_ (indicate)

\_\_\_\_\_  
Printed Name of Minor (when applicable)\*\*\*

\_\_\_\_\_  
Signature of Minor (when applicable)\*\*\*

\_\_\_\_\_  
Date