Yale NewHaven Health
Westerly Hospital

Authorization for Release of Information

Patient Legal Name: _____ _____ ___ _____ _____
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Address: _____
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 Format: ☐ CD-ROM

Medical Information Requested:

Date of Service(s): _____ **Or Date Range From:** _____ **To:** _____

☐ Hospital Admission Summary (Includes: History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

☐ Consult Report	☐ History & Physical Exam/HP	☐ Operative/Procedure Report	☐ Pulmonary Function Test
☐ Discharge Summary/DS	☐ Immunization Record	☐ Outpatient Visit Notes	☐ Radiology Report
☐ Echocardiogram/EKG	☐ Lab Results	☐ Pathology Report	☐ Stress Test
☐ Emergency Visits/ED	☐ Medication List	☐ PT/OT/Speech Notes	☐ Other: _____

☐ Complete Medical Record *(Excludes data collection flowsheets unless specifically requested).* ☐ Include Flowsheets

The following item(s) will be sent separate from medical records: ☐ *Itemized Bill*

To request Radiology Images, visit www.ynhh.org; select Patients & Visitors; then select Request Medical Records,or scan the QR Code below. To speak directly with the Image Library, please contact 203-688-6054 for further assistance.

SENSITIVE INFORMATION: I understand that the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, sexually transmitted disease, HIV/AIDS, reproductive health, gender affirming care, or testing/history of drug or alcohol use. By signing this authorization, I agree to the release of this information. I have the right to have my medical records released directly to me so that I can review and inspect the information. This includes reviewing the records for sensitive information I do not wish to be disclosed to a third party.

This general authorization is not sufficient for the release of Substance Use Disorder Program information. To request this information, visit www.ynhh.org; Select Patients & Visitors; then select Request Medical Records, or scan the QR Code on page 1.

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 use treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- 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) except where the records relate to treatment(s) which is protected under state law, in which case the minor must consent to release of the protected information. Signature of a minor age 13 or older is required for release of records related to HIV/AIDS, substance use (alcohol/drug treatment), pregnancy and pregnancy prevention, and/or sexually transmitted disease. Signature of a minor age 16 or older is required for release of behavioral health records

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

Mailing Address: **Westerly Hospital**
Health Information Management
Release of Information Services
25 Wells Street
Westerly, RI 02891

Westerly Hospital Fax Number: **401-348-3774** **Email to:** **releaseofinfo@westerlyhospital.org**

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 401-348-3262.

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

WH000006_English (Rev. 04/26)
Available in Multiple Languages