Yale Medicine **Yale New Haven Health**

Authorization for Access/Release of Information

Patient Name: _____ _____ _____ _____
(Last) (First) (Middle Initial) (Maiden/Other Name)

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

_____
Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: ☐ Personal use ☐ Continuing care ☐ Legal ☐ Disability ☐ Workers Comp
☐ Insurance Eligibility/Benefits ☐ Social Security Card ☐ Other _____

I hereby authorize Yale New Haven Health/Yale Medicine entity(ies) named below

☐ **to release information from my medical record to:** ☐ **to obtain information from:**

Name: _____ **Phone:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Fax (optional): _____ **Email** (optional): _____

Method of Disclosure:
☐ Mail ☐ Fax ☐ Secure Email ☐ Pick-up Please indicate how you would like to be contacted when ready for pick-up: _____

Date(s) of Service: _____

Service Type: ☐ Admission ☐ Same Day Surgery ☐ ED Visit ☐ Physician Office/Clinic Visit Other ☐

Location: ☐ Yale New Haven Hospital (York Street Campus/St. Raphael's Campus) ☐ Smilow Care Center
☐ Bridgeport Hospital ☐ Greenwich Hospital
☐ NEMG (North East Medical Group) Provider/Practice Name: _____
☐ Yale Medicine/Yale School of Medicine Provider/Practice Name: _____
☐ *Not sure of Physician Group.* *Provider/Practice Name:* _____

Medical Information Requested:

☐ Abstract of Medical Record (History & Physical Exam, Discharge Summary, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

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

☐ Complete Medical Record (Includes all of the above, plus nursing notes, ancillary notes, and consents. Excludes nursing flowsheets unless specifically requested).

☐ Itemized Bill ☐ Radiology Image(s): _____
Please note date and type

Reasonable cost-based fees apply.

*****HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. **(Medical records containing any of the protected information below must also be signed by the patient if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if a minor age 16 or older.)*****

Indicate which you do NOT want released with your initials:

____ HIV ____ Substance Abuse which includes Alcohol & Drug Abuse ____ Pregnancy Test ____ Genetic Testing

____ Behavioral Health/Psychiatric ____ Sexually Transmitted Disease ____ Other (please list) _____

- The 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 the YNHHS Medical Information Unit. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- I understand 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.
- I understand 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.
- I understand that I may see and copy 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 for a patient age 13 or older, the minor must sign as described above.

Return completed authorization by mail or fax to the designated fax number below.

Mailing Address:	**Yale New Haven Health** **Health Information Management** **Release of Information Services** **PO Box 9565** **New Haven, CT 06535**
YNHHS Hospital Fax Number:	**203-688-4645**
NEMG Provider Fax Number:	**203-200-1286**
Yale Medicine/YM Provider Fax Number:	**203-200-1287**
If unsure of provider group or if requesting medical records from multiple locations, fax to:	**203-688-4645**

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