Connecticut Orthopaedic Surgery Center
Milford

MEDICAL RECORD RELEASE AUTHORIZATION/REQUEST

Patient:_____ DOB:_____ MR#:_____

Current Address: _____ City, State, Zip: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

I authorize information to be sent to:

_____
Self, Physician, or Third Party Named

_____
Address

_____
City, State, Zip

_____
Fax

Purpose of Release (check one box):

☐ Referral/Consultation ☐ Legal

☐ Personal Use ☐ Insurance

☐ Other _____

Indicate type of information to be released below:

☐ Operative Report ☐ Laboratory Results requisitioned through SSC

☐ Anesthesia Record ☐ Other _____

For the following date/(s): _____, _____, _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. **Initials:** _____
b. I understand that I may see and copy the information described on this form if I ask for it, and that Southington Surgery Center will give me a copy of this form after I sign it. **Initials**: _____
c. I understand that this authorization will expire 30 days from the date I sign this form. **Initials**: _____
d. I understand that I may revoke this authorization at any time by notifying Southington Surgery Center in writing, but if I do revoke it, the revocation will not have any effect on any actions Southington Surgery Center took before it received the revocation. **Initials:** _____
e. I understand that once released**,** the record custodian, or its employees have no responsibilities or liability that may arise regarding any aspect of this authorization**. Initials:** _____

I understand that there may be charges associated with copying my medical record and assume responsibility for these fees.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name of Patient or Patient's Legal Representative Relationship to Patient

RETURN BY MAIL OR FAX:

Connectcut Orthopaedic Surgery Center
205 Sub Way | Milford, CT 06461 | Phone: 860-446-7800 | Fax: 860-446-7801

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