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 COSC

☐ 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 Connecticut Orthopaedic 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 Connecticut Orthopaedic Surgery Center in writing, but if I do revoke it, the revocation will not have any effect on any actions Connecticut Orthopaedic Surgery Center took before it received the revocation. **Initials:** ____
e. I understand that once released, the record custodian, or its employees have no responsibility 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:

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