Family Osteopathy
Hands-on Holistic Care

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PRIME HealthCare, PC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ____ **Date of Birth:** ______________

I, the undersigned patient or legal representative, hereby authorize Family Osteopathy to disclose or obtain health information, **including if applicable**, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and/or confidential HIV related information regarding:

Provider/Facility: ___________________________________ Telephone: _____________________

Address: ____ Fax: _______________________

The purpose of this disclosure or use is for the following reason:
□ Medical □ Legal □ Disability □ Insurance □ Transfer of Care □ At the request of the patient

The dates of service and the type(s) of information to be used or disclosed are as follows:
□ History & Physical □ Radiology Films □ Discharge Summary □ Office Visit □ Operative Reports
□ Consultations □ Laboratory Reports □ Radiology Reports □ ED Record □ Pathology Reports
□ Progress Reports □ Billing Records □ Entire Pt. Chart □ Other ________________________

Date(s) of Treatment: □ All dates OR □ Limited to the following dates: ________________________________

Method of Disclosure:
□ Pick-up Copy □ Mail Copy □ FAX Copy □ Review

- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by Family Osteopathy is in no way conditioned on whether I sign this authorization and that I may refuse to sign it.
- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Family Osteopathy in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- The parent or legal guardian must sign this authorization if the patient is a minor (under 18) or has a legal guardian.
- Minors receiving drug abuse treatment or treatment for venereal disease may sign their own authorization.

Copy Fees: I understand that if a physical copy is requested, Prime Healthcare, PC may charge a fee for copying and first-class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut State Statute at $0.65 per page.

___________________________________ ___________________________

Signature of Patient or Legal Guardian **Today's Date**

If not the patient, state your relationship to the patient below (legal documentation required as applicable):
□ Parent □ Guardian □ Conservator □ Executor of Estate □ Power of Attorney □ Other ____________________

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFW, part 2. This information shall not be re-disclosed to anyone else without written consent or other authorizations as provided by the Connecticut General Statutes and/or Federal Regulation 42 CFR, part2. A general authorization for release of medical information is not sufficient for this purpose.