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MEDICAL RECORDS RELEASE REQUEST FORM

As required by the Health Insurance Portability and Accountability ACT of 1996 (HIPPA) and Connecticut Law, the practice may not use or disclose your individual identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and purpose for the disclosure.

As referenced in section 20c(b), Connecticut General Statutes allow a charge of \$0.65 per page to copy medical records, plus the shipping and handling or any conveyance fees this office is required to pay. Fees are payable in advance.

Transfer of Medical Records

Request for Medical Records

I hereby authorize this medical practice _____
to release health information of patient (named below)

Patient Name: _____ DOB: _____

Dates of Service to Release: _____ Reason for Release: _____

Send Medical Records to (Physician or Practice):

Name: _____

Address: _____

Fax: _____ Phone: _____

I understand that I may revoke the authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that I also have the right to receive a copy of this authorization.

Printed Name: _____

Signature: _____ Date: _____

If signing on behalf of the patient, I am the:

Parent

Guardian

Conservator/POA

Patient's Representative

CONFIDENTIALITY

The document accompanying this transmission contains information from Women's Health Associates, which is confidential and/or legally privileged. The information is intended only for use by the individual or entity names on the transmission sheet. If you are not the intended recipient, you are hereby notified that using, disclosing, copying, distributing or taking any action in reliance on the contents of the transmitted information is strictly prohibited and that the document should be immediately returned to Women's Health Associates.