FAMILY HEALTH CARE CENTER
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• • *SIGNED AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION* • •

Family Health Care Center will not release your Medical Records unless ALL INFORMATION IS COMPLETELY FURNISHED.

PATIENT'S NAME- _____
First Middle Last

PARENT'S NAME IF A MINOR _____

PATIENT'S ADDRESS- _____ TELEPHONE # _____

DATE OF BIRTH: _____ S.S # _____

HEREBY REQUEST AND AUTHORIZE DR _____

TO RELEASE TO/ FROM _____
(Physician Name/ Practice Name)

AT _____
(Address, City, State & ZIP Code)

ANY AND ALL MEDICAL RECORDS [From _____ To _____] TO BE RELEASED OF MY OWN OR MINOR CHILD INCLUDE THE FOLLOWING: (Please Initial) ***FOR THE PURPOSE OF:*** _____

☐ Annual Exams	❑ Progress Notes	❑ Alcohol & Drug Abuse Information
❑ Laboratory Reports	❑ Consultants Reports	❑ Psychiatric Information
❑ Operative Reports	❑ Gynecological Reports	❑ H.I.V. Treatment, tests, all Information
❑ X-ray Reports	❑ Psychology Reports/Evaluation	❑ S.T.D. Testing and Information
❑ Sickle Cell	❑ Infectious Disease Report	❑ Other
		❑ Billing HX - From _____ To _____

SPECIFIC DIAGNOSIS OR TREATMENT, ACCIDENT, ETC (If Known)

*****PLEASE SPECIFY ANY INFORMATION YOU DO NOT WANT RELEASED*** _____

This authorization will remain in effect a maximum of six (6) months from the date of signature and may be cancelled by me in writing at any time. A photocopy of this authorization will be treated in the same manner as the original. Copies of the records can be obtained with reasonable notice and pre-payment of copying cost as authorized by The State of Connecticut. I further understand that if the person/entity that receives the above authorized information is not a Health Care Entity covered by the federal privacy regulations, the authorized release of confidential medical information may be redisclosed and no longer protected by the privacy regulations. I understand I have the right to receive a copy of this authorization.

DATE: _____ _____
(Signature of Patient/Guardian)

_____
(Relationship to Applicant)

WITNESS: _____ DATE _____

THE CONFIDENTIALITY OF THIS RECORD IS REQUIRED UNDER CHAPTER 899 OF THE CONNECTICUT GENERAL STATUTES. THIS MATERIAL SHALL NOT BE TRANSMITTED TO ANYONE WITHOUT WRITTEN CONSENT OR OTHER AUTHORIZATION AS PROVIDED IN THE AFOREMENTIONED STATUTES CGS. S52-146i