CareMedica
52 Washington Ave, Suite 4, North Haven, CT 06473
Phone 203-672-2800 Fax 203-672-2801
AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME:_____

Any Other Previous Names: _____ Date of Birth: _____

Patient Address: _____ Phone Number: _____

City:_____ State:_____ Zip:_____ Email:_____

I hereby Authorize CareMedica to:
Please choose one: ___Release my Medical Information to ___Obtain medical information from
Name/Facility: _____ Attention: _____
Address: _____ Phone Number: _____
City:_____ State:_____ Zip:_____ Fax #:_____

Purpose of Request: __Personal __Referral or 2nd Opinion __ Legal __ Insurance __Other: _____
Workers Comp (only) Date of Injury_____ Body Part Treated _____

Specific Records/Report(s) to be released: (allow 7-10 days for turnaround of request)
Date of Service: _____
__ Consultation/Progress Reports __ Radiology Reports __ Labs __ Bills
__ Physical Therapy Notes __ All Immunizations __Med List __ Problem List
__ Other Please Specify_____
__ Enter Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure.)

Restricted Authorization to Release Protected Information:
IMPORTANT- It is extremely important that you select either "**DO**" or "**DO NOT**" for each item contained in this section **Authorization to Release Protected Information**. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.
Release Records? Check one
I __ DO __ DO NOT want **Mental/Behavior Health or Disability Services Provider Documentation *** released.
I __ DO __ DO NOT want **HIV/AIDS Screening Test Results** released.
I __ DO __ DO NOT want information about **Alcohol and/or Substance Abuse Treatment *** released.
I __ DO __ DO NOT want **Genetic Testing/Test Results **** released.
I __ DO __ DO NOT want **Confidential Communications with a Social Worker** released.
I __ DO __ DO NOT want information about **Rape/Sexual Assault Victim's Counseling** released.
I __ DO __ DO NOT want **Child/Elder Abuse or Neglect & Abuse of an adult with a Disability** released.
I __ DO __ DO NOT want information about **Sexually Transmitted Diseases (STD's)** released.
I __ DO __ DO NOT want information about **Domestic Violence Victims Counseling** released.
*This Authorization is not valid for use or disclosure of psychotherapy notes
** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.
*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general Medical Facility.

Patient's Signature: _____ **Date**: _____

_____
Signature of Personal Representative **Date** **Relationship to Patient or authority to act for patient**

I understand the following:
A: I may revoke this authorization at any time by providing written notice to the practice.
B: I may not be able to revoke this information if the practice has already acted utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance information.
C: The practice will not condition treatment or payment based on my signing this authorization.
D: I am signing this authorization freely.
E: No one has pressured me to sign this authorization.
F: The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law.
G: I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
H: I have received a copy of this authorization.
I: I understand that there is a $.65 cent per page fee for my records and that I will receive a billing statement from Ciox Health.