ProHealth™ PHYSICIANS
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ProHealthMD.com

Authorization to review or obtain copies of medical records (page 1 of 2)

I, _____ (print name), authorize ProHealth Physicians to release the medical records of _____ (print name of patient), _____ (patient's date of birth).

The records should be sent to:

_____

Recipient name Street address city, state, ZIP code

Note: there is a 65-cent per page copying charge generally allowable under Connecticut State Law

Information to release

I request that the information to be used or disclosed consist of the following (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information*).

Check all that apply:

- ☐ Complete medical record (including records from prior providers)
- ☐ Only medical record from ProHealth providers
- ☐ Medical history, evaluation records
- ☐ X-ray reports
- ☐ Laboratory reports
- ☐ Hospital records, including reports
- ☐ Immunizations
- ☐ Prescription data
- ☐ Consultation documentation
- ☐ Surgical reports
- ☐ Summary of record
- ☐ Other (specify): _____

☐ Sensitive information regarding HIV/AIDS, or treatment for substance abuse (alcoholism or drug abuse) and/or mental health issues may be disclosed.

☐ I do not authorize the release of sensitive information regarding HIV/AIDS, or treatment for substance abuse and/or mental health.

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Authorization to review or obtain copies of medical records (page 2 of 2)

Purpose of use/disclosure

It is my understanding that the information to be used or disclosed will be used for the following purposes.

Check all that apply:

☐ At the request of the individual signing this authorization (no purpose need be specified)

☐ Additional medical care
☐ Insurance eligibility/benefits
☐ Change of provider
☐ Legal investigation or action
☐ Other (specify): _____

REDISCLOSURE: I understand that the disclosed information may be redisclosed in accordance with law and may no longer be protected by privacy requirements. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected. However, other state or federal law may prohibit the recipient from disclosing specially protected information, e.g., substance abuse treatment information, HIV/AIDS-related information, and mental health information.

INDIVIDUAL'S RIGHTS: I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that ProHealth Physicians may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying ProHealth Physicians in writing of my revocation. To revoke or to receive a copy of my revocation, contact ProHealth Physicians' Privacy Official, 3 Farm Glen Boulevard, Farmington, CT 06032, Attn: Privacy Official. I am aware that my revocation will not be effective until received by ProHealth and will not affect uses and/or disclosures prior to its receipt.

ALTERATION: This authorization may not be altered in any manner. If altered, in the sole discretion of ProHealth it may be considered void and of no effect.

EXPIRATION DATE: This Authorization is valid for one year from the date signed unless otherwise specified here: _____

Signature: _____

Circle one: Patient/Parent/Health care representative/Executor/Administrator*

Printed name: _____ Date: _____

**Attach copy of appointment as health care representative/executor/administrator*

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Nondiscrimination Notice and Access to Communication Services

ProHealth Physicians does not discriminate on the basis of sex, age, race, color, national origin, disability, or on the basis of any other discrimination prohibited by applicable law.

Free services **are** available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number 1-855-286-3411.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, disability or any other discrimination prohibited by applicable law, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Fax: 855-351-5495
Email: **Optum_Civil_Rights@Optum.com**

If you need help with your complaint, please call the toll-free number 1-877-773-5388. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Language Assistance Services and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the toll-free number 1-855-286-3411.

Language Assistance Services and Alternate Formats, continued

1	Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-286-3411.
2	Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-286-3411.
3	Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-286-3411.
4	Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-286-3411。
5	Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-286-3411.
6	French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-286-3411.
7	French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-286-3411.
8	Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-286-3411.
9	Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-286-3411.
10	Arabic	لحوظة: إذا كنت تتحدث اللغة إن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1- 855-286-3411.
11	Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-286-3411번으로 전화해 주십시오.
12	Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-286-3411.
13	Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-286-3411 पर कॉल करें।
14	Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-286-3411.
15	Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-286-3411.