ProHealth PHYSICIANS
Part of OptumCare

# Authorization to Disclose Medical Record Information

***Please send completed form to:***
ProHealth Physicians, ATTN: Medical Records, 3 Farm Glen Blvd, Farmington, CT 06032

**Patient Information**

Patient's Name: _____

Patient's Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____ Phone #: (  )_____

**Release Information**

*I authorize ProHealth Physicians to:* ☐ **Send my medical records to:** ☐ **Request my medical records from:**

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Continued Care (Appt. with Specialist) ☐ Legal ☐ Insurance
☐ Transfer of care (New Physician) ☐ Other: _____

**Information to be Released**

**Please specify date ranges.*

☐ Abstract (*Generally recommended for transfer of care. It includes 2 years of notes and labs and 5 years of diagnostics.)

☐ Office Visits *_____ to ____ Specify Provider(s): _____

☐ Lab Results: *____ to ____ ☐ Radiology/Imaging Reports: *_____ to _____

(If radiology **images**, please contact the radiology department directly: (1-877-643-8759)

☐ Other *(please be specific)*: _____

**Legally Protected Information**

***The following items will not be included, unless specifically authorized.***

| | | | |
|---|---|---|---|
| ☐ Genetic Testing | Initial: _____ | ☐ Psychiatric Health (Include Behavioral Medicine Notes) | Initial: _____ |
| ☐ HIV/AIDS Results | Initial: _____ | ☐ Substance Use Disorder Care *(42 CFR Part 2Records)* | Initial: _____ |
| ☐ Sexually Transmitted Diseases | Initial: _____ | ☐ Reproductive Health Care Services | Initial: _____ |

**Fees & Format**

*We may charge a fee for asking and sending copies (HIPAA 45CFR, 164.524). For many patients, an Abstract (2 years of notes and labs and 5 years of diagnostics) is enough for their care. For a complete record or more than 3 years of notes, the rate may go up due to cost. At no time will the cost-based fees exceed Connecticut law (Section 20-7c of the CT General Statutes).*

**Preferred format for release** *(file size restrictions may apply)*

☐ Paper. ☐ Fax ☐ Patient Portal

- *I understand I can cancel this authorization at any time. I must give a written statement to ProHealth Physicians to cancel. Canceling won't affect information already shared with consent. I understand this authorization is good for 12 months, unless noted or canceled. Please note an expiration date if less than 12 months:___/___/___.*
- *I understand that granting the release of this health information is not required. I do not need to sign this form to get care.*
- *I understand that my health record may have details on my mental health, substance abuse disorders or otherwise sensitive information. Releasing information may lead to unauthorized re-release. Which may not be protected by federal confidentiality rules.*

**Signatures**

Patient/Legal Representative* Signature: _____ Date: _____

Print Name of Legal Representative: _____ Relationship to Patient: _____

**You must show proof that you're an authorized representative with access to members'/patients' records. Include the signed authorization with this request.*

***This authorization must be completed in its entirety or it will not be processed.***