AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please send information including diagnosis and records of any treatment or examination rendered to:

Patient_____________________________________ **DOB** __________________________
Patient_____________________________________ **DOB** __________________________
Patient_____________________________________ **DOB** __________________________
Patient_____________________________________ **DOB** __________________________

[ ] **TO**:	[ ] **FROM**:
Litchfield County Pediatrics 20 Felicity Lane Torrington, CT 06790 Phone: 860-489-4144 Fax: 860-489-4412	Litchfield County Pediatrics 20 Felicity Lane Torrington, CT 06790 Phone: 860-489-4144 Fax: 860-489-4412
FROM: ________________________________ ________________________________ ________________________________ ________________________________	TO: ________________________________ ________________________________ ________________________________ ________________________________

Please Check One:

[ ] **Copy of complete and entire medical record** including all records for care and treatment, including psychiatric and drug information, and information regarding HIV/Aids status, treatment or testing, emergency room records, nursing notes, laboratory results, pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered.

[ ] **Immunization records only**

[ ] **Other:**____

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes. If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the C.F.R., which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above. I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

Signature of patient/parent/guardian: __________________________ **Date:** __________________________
Printed name:______________________________

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