Please mail records to the address listed
Please do not fax

Cornell Scott-Hill Health Center
400 Columbus Ave
Attn: H.I.M DEPT
New Haven, Ct. 06519
P: (203) 503-3140- 203-503-3236
F: (203) 503-3143

1. **Patient Information**

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

Patient's address _____ Phone # _____

City _____ State _____ Zip _____ Work # _____

2. **Release of information** * (CS-HHC reserves the right to charge a reasonable fee for the cost of producing and mailing copies under [CGS §20-7c (b)] which is 65 cents per page plus postage (Includes research, handling and related costs)

Ongoing communication, ☐ I authorize reciprocal information exchange as specified below.

I authorize Cornell Scott-Hill Health Corporation (CS-HHC) to ☐ RELEASE or ☐ OBTAIN my medical record information as specified below:
Name of individual, organization, facility or provider:

_____

Address _____

City _____ **State**_____ **Zip**_____

Phone_____ **Fax** _____

3. **Purpose of request:** Please specify the purpose(s) for which the information is being requested by this authorization:

☐* Personal ☐ Continuing care ☐ Transfer of care ☐ *Legal ☐*Insurance ☐ Coordination of care

☐* Disability ☐ Workers Compensation ☐ Other _____

4. **Information to be released:** Please OBTAIN, RELEASE or EXCHANGE the following health information, if such information exists:
   - ☐ All information maintained at any time by CS-HHC and affiliated sites
   - ☐ Dates of service. From: _____ To: _____

OR; the following limited health information
☐ Records of OB/GYN visits ☐ Diagnostic reports ☐ Progress Notes ☐ lab Tests ☐ Intake Evaluation ☐ Discharge Summary
☐ Immunization Records ☐ Other _____

5. **Authorization for Release of Statutory Information** PHI **cannot** be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations and Chapter 899 of the CT General Statutes**. Please initial next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for:**

HIV/AIDS status/information ☐ yes ☐ no Initials _____
Drug and alcohol abuse ☐ yes ☐ no Initials _____
Mental health/psychiatric disorders ☐ yes ☐ no Initials _____

I understand that signing this authorization is voluntary and that CS-HHC may not require me to sign this authorization before CS- HHC provides me with treatment. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to CS-HHC. I understand that a description of my right to revoke my authorization is set forth in CS-HHC's Notice of Privacy Practices. **I understand that the information released pursuant to this authorization may be re-disclosed by the recipient without our knowledge.**

6. **Unless revoked sooner, this authorization expires in 1 year from the date of signature**

_____ _____
Signature of Individual Date

_____ _____
Signature of Personal Representative* Date

**If signed by the individual's personal representative, describe the legal authority of the representative to act on behalf of the individual and attach legal documentation to support: _____

****Witness/ Legal authority of representative OR personal picture ID verified by:** _____