



AUTHORIZATION TO DISCLOSE & TRANSFER HEALTH INFORMATION

I, _____ authorize Greater Hartford Orthopedic Group, P.C. _____ to release my health information, as described below, to:

RECIPIENT(S) INFORMATION:

Name of Health Care Provider/Plan/Other	Name of Health Care Provider/Plan/Other		
_____	_____		
Mailing Address	Mailing Address		
_____	_____		
City, State, Zip Code	City, State, Zip Code		
_____	_____		
Telephone#	Fax #	Telephone #	Fax #
_____	_____	_____	_____

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 except other psychotherapy notes*).

CHECK ALL THAT APPLY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Medical History, Evaluation Records | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records Including Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Imaging Reports |
| <input type="checkbox"/> Consultation Documentation | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Prescription Data |
| <input type="checkbox"/> Other (Specify): _____ | | |

I also **specifically authorize** that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health may be used by or disclosed to the above referenced recipients. **YES / NO**

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

CHECK ALL THAT APPLY:

- | | |
|--|--|
| <input type="checkbox"/> At the request of the individual (no purpose need be specified) | <input type="checkbox"/> Additional Medical Care |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Change of Provider |
| <input type="checkbox"/> Other (Specify): _____ | <input type="checkbox"/> Legal Investigation or Action |

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 by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:

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 Greater Hartford Orthopedic Group, P.C. may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying Greater Hartford Orthopedic Group, P.C. in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact Greater Hartford Orthopedic Group, P.C.' Privacy Official at 1000 Asylum Avenue, Suite 2126, Hartford, CT 06105, Attention: Practice Administrator. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE

REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)

PRINT NAME

DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP

DATE: _____