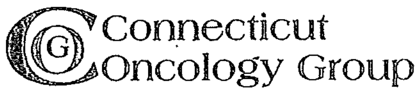

Note to Requestor of Records:
There may be a $.65 per page charge for copies of the medical record.

Authorization to Release or Obtain Information

Name of Patient: ______________________________ DOB ___/___/___

I hereby authorize CT ONCOLOGY GROUP to release/obtain all medical information with respect to the treatment of the above-referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

The Name or Specific Identification of Persons to Whom Disclosure: ☐ **Records may be released to** ☐ **Obtained from:**

Name:______________________________ Phone No.:______________

Address:______________________________

City:______________________________ State:________ Zip Code:______________

Indicate Delivery Preference (select one)

☐Mail ☐On-site pick-up
☐Email (Please provide email address)______________________________

Description of the Purposes of the Requested Disclosure:

☐ Personal	☐ New Physician	☐ Social Security Disability.	☐ Other:______________
☐ Primary Care Physician	☐ Medical Ins. Claim	☐ Life Insurance	______________
☐ Consultation	☐ Workers' Comp	☐ Attorney	

CHECK ALL THAT APPLY:

____**COMPLETE** Medical Record	____Medical History, Evaluation Records	____Immunizations
____Treatment or Tests	____Hospital Records Including Reports	____X-ray Reports
____Allergy Records	____Laboratory Reports	____Prescription Data
____Consultation Documentation	____Surgical Reports	
____Other (Specify):______________________________		

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 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 CT Oncology 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 CT Oncology Group, P. C. in writing of my revocation. To obtain information on how to revoke by Authorization or to receive a copy of my revocation, I am to contact CT Oncology Group, P. C.'s Privacy Official at 536 Saybrook Road, Middletown, CT 06457 ATT: Privacy Official. 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.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition:______________
If I fail to specify an expiration date, event or condition, this Authorization will expire in one year.

______________ ______________________________
Date Signature of Patient or Person granting Authorization on behalf of patient

If signed by the Legal Representative, indicate your relationship to the patient below and attach a copy of the documentation:

☐ Conservator ☐ Power of Attorney ☐ Executor of Estate ☐ Other:______________

536 Saybrook Road
Middletown, CT 06457
Phone 860.358.2220 **Fax** 860.358.2222

90 Main Street
Suite 102
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