CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS
www.ctkidneyspecialists.com

Medical Record Release Authorization

PATIENT NAME: ___________________________________ **DATE OF BIRTH:** ____________________

We want to assure you that your medical/ protected health information is secure with us.
This notice contains information about how we will ensure that your information remains private and secure.

Release of Medical Information **(PLEASE CHECK APPLICABLE BOX)**

☐ **INFORMATION REQUESTED FROM:**
Practice or Doctor's Name: ____
Phone Number:_____________________________________ Fax Number: ___________________________________
Practice Address:____

Description of the Medical Information to be disclosed:____

☐ Discharge Summary ☐ Radiology Reports ☐ Pathology Reports ☐ Consultation ☐ Other________________
☐ Clinical Notes ☐ Lab Reports ☐ Operative Reports ☐ Hospital Records

☐ **SEND INFORMATION TO:** ☐ Please Fax Records ☐ Please Mail Records
This information may be disclosed and used by the following individual or organization:
Release To: **Connecticut Kidney and Hypertension Specialists**

☐ Address: 140 Grandview Ave Suite 101 Waterbury, CT 06708 Phone: 203-597-9733 Fax: 203-597-9732

☐ Address: 30 Peck Road Suite 2201 Torrington, CT 06790 Phone: 860-489-1984 Fax: 860-496-2195

The Release of Medical Information is for:
☐ Change of Physician ☐ Continuation of Care ☐ Referral ☐ Other ________________

☐ All information regarding assessment, diagnosis, treatment, laboratory results for the above listed patient for the following dates: From ______________________________ To ___________________________________
(month/year) (month/year)

☐ Other information (specify): ____

I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written request to the Practice Manager at CT Kidney and Hypertension Specialists. I understand that the request will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 1 year from the date signed.

I understand that my full and complete medical records may include information regarding drug and alcohol use, mental health information and or history of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I understand that authorizing the disclosure of this health information is voluntary. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature / Guardian or Authorized Representative **Date**

Printed Name of Authorized Representative **Relationship to Patient**