STAMFORD PEDIATRIC ASSOCIATES, P.C.

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

DATE: _____

Patient/Client name: _____ D.O.B. _____
Patient/Client name: _____ D.O.B. _____
Patient/Client name: _____ D.O.B. _____
Patient/Client name: _____ D.O.B. _____

Patient home address (for verification): _____

Patient telephone number (in case we have questions): _____

I, _____, hereby authorize the practice to release my medical health records including a copy of my complete and entire mental health record, all records for my care and treatment, including psychiatric and drug information, and information regarding HIV/AIDs status, treatment or testing, emergency room records, nursing notes, laboratory results (individually copied), pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered, to: _____ .

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 Code of Federal Regulations, which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

The information to be used/disclosed consists of:

- o My entire record
- o A portion of my record (describe) _____.

Note: This description must be specific and meaningful. If all records are being authorized for release, "entire record" should be stated.

The information will be used/disclosed for the following purposes:

- o Moved out of the area
- o Leaving the practice: _____
- o reached adulthood
- o Need the records to see a specialist: _____ (not leaving practice)

- o Need the records for insurance or legal matters: _____ (not leaving practice)
- o CD made of medical records Paper Records made

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.

The authorization expires _____ .

_____ _____

Signature of Patient/Client or his/her authorized representative, Or parent or guardian if a minor, please specify relationship to patient/client.

Date

If a representative signs, describe the representative's authority to act on behalf of the patient:

_____

PLEASE SEE THE FOLLOWING PAGE OF THIS FORM FOR SPECIAL DISCLOSURE INFORMATION REGARDING MENTAL HEALTH, DRUG AND/OR ALCOHOL ABUSE, AND HIV-RELATED INFORMATION.

TO THE RECIPIENT OF THESE MATERIALS:

HIV/AIDS INFORMATION: In the event that any of the disclosed information includes HIV/AIDs information, this is protected under state law as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." Any oral disclosure shall by accompanied or followed by the above notice. See Connecticut General Statute section 19a-585.

PSYCHIATRIC COMMUNICATIONS: If the released material contains confidential psychiatric communication, as designated in C.G.S. sections 52-146d through 52-146i, inclusive, please note the following:

> "The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes." A copy of the consent form setting forth any limitations shall accompany the disclosure.

DRUG & ALCOHOL TREATMENT: No person, hospital, treatment facility or department of health may disclose or permit the disclosure of the identity, diagnosis, prognosis or treatment of any patient in a treatment for drug and\or alcohol abuse that would be in violation of federal or state law. In the event that the records contain information regarding drug and\or alcohol abuse treatment, please note the following legal requirements and prohibitions:

> "This information has been disclosed to you from records protected by federal and state confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." See Connecticut General Statute section 17a-688.

STAMFORD PEDIATRIC ASSOCIATES

Dear Parent / Guardian:

Starting on October 1, 2008, Stamford Pediatric Associates, P.C., will charge sixty-five cents ($.65) per page for requested copies of patient medical records, plus any postage required to mail records. For many years our practice did not charge for copies, and absorbed the costs of copying. Unfortunately, rising administrative and copying costs has forced us to change this policy. The Connecticut legislature recently recognized that medical offices cannot continue to absorb these costs, and set the fee at sixty-five cents per page beginning October 1st.

Great news, effective December 8, 2008, we now have the ability to burn electronic records to a CD. All records on our EMR system can be given to you on a CD for $5.00. Paper records will continue to cost $.65 per page. All of our patients' records are electronic starting from December 2005. All records prior to that date were on paper. The electronic record automatically includes immunization records and growth charts.

When you request a copy of your records, you will be informed of the fees associated with copying and/or a CD and you will be responsible for paying those fees. You will still need to sign a HIPAA authorization form before we can release the records.

If you have any questions, please contact our business office.

Sincerely,

Stamford Pediatric Associates

STAMFORD PEDIATRIC ASSOCIATES

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Phone: 203-324-4109
FAX: 203-969-1271

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Darien, CT 06820
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