AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name: ____ **DOB:** ____________________________

By signing this form, I (the patient or legal representative) authorize ____________________________(Physician/Provider) at Starling Physicians to either send a copy of my (or my child's) medical records or to obtain a copy of my (or my child's) medical records: Please complete information below as to who to send records to or receive records from:

Physician/Provider Name:		**Telephone:**	
Address:		**Fax:**	

Relationship to patient: Patient Parent Guardian Legal Representative Other: ______________________________
Minor child's Name: ____ **DOB:** ___________________________________

I authorize the following **PHI** (Protected Health Information) be sent for the sole purpose of: (*Select option below)*
* Transfer of Care Second Opinion Relocation Other ____
****For transfers of care, I understand that my patient/physician relationship will be terminated 30 days from the date of my signature and that I will no longer be considered an active patient.***

The dates of service and type(s) of information to be disclosed shall include: (please check the appropriate boxes below)
Provider ________________________ Specialty_______________________ Location ______________________

Include only the following specified information/records from the medical record:
History & Physical Operative Reports Pathology Reports Consultations Progress Notes
P T/OT/ST Notes Laboratory Results Radiology Reports Radiology Films Billing Records
Psychotherapy Notes (If this box is checked, no other information may be requested in the Authorization)
Other (please specify):____

Dates of treatment covered by this release: All dates, or **Limited to the following dates:** ___________________________
All medical records and information/records received from other health care providers.

Psychotherapy notes will not be included unless you provide separate authorization by initialing here ___.

I understand that state law prohibits the use and/or disclosure of the following types of *PHI* below without specific authorization by me. I indicate my authorization to release this information by initialing next to each option selected below:
Genetic Testing___ HIV (AIDS) related information___ Drug and/or alcohol abuse treatment information___
Sexual transmitted disease information___ Sexual abuse/assault and domestic violence records___
Mental health records___ Psychiatric Information___

My rights regarding this authorization: I understand that this permission form is only good for one year from the date I sign it, unless I indicate a different date here: _____________.
I may cancel my permission at any time by writing a letter to cancel this permission or signing the cancellation below and sending it to Starling Physicians PC, Attention: Privacy Officer at 2110 Silas Deane Highway, Rocky Hill, CT. I understand that Starling Physicians, PC may have already sent my records prior to receiving my cancellation. Further, I understand that my medical treatment will not be affected if I do not sign this form. I understand that I may look at my medical records or receive a copy before they are sent. I further understand that this consent does not protect my personal health information from being disclosed by the receiving party. According to state law, I will be charged a copy fee of .65¢ per page when applicable. ***My signature below indicates that I have read and understand this Authorization and its terms.***

____ _________________________________

Patient Signature or *Legal Representative **Date**
*Provide legal documentation

<u>Cancellation of Authorization:</u>

____ _________________________________

Signature of Patient or *Legal Representative **Date**

Rev. 5/15/2018