Trinity Health Of New England

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I am requesting my protected health information (PHI) from:

☐ **All** Trinity Health Of New England Hospital Locations **OR**
☐ Johnson Memorial Hospital ☐ Saint Francis Hospital
☐ Mount Sinai Rehabilitation Hospital ☐ Saint Mary's Hospital
☐ Mercy Medical Center

☐ **All** Trinity Health Of New England Medical Group Locations – CT **OR** ☐ Trinity Health Of New England Medical Group – CT: (specify below)

PRACTICE NAME _____ MEDICAL PROVIDER NAME _____

☐ Other PRACTICE NAME _____ MEDICAL PROVIDER NAME _____

PATIENT INFORMATION

Patient Full Name: _____ Date of Birth: ____/____/____

Other Names During Treatment? _____ Phone #: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

RELEASE INFORMATION TO

Name / Facility: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer / Reason: _____ ☐ Other: _____

Delivery Method: ☐ US Mail ☐ Email ☐ In-Person (Pick-up) ☐ MyChart ☐ Fax ☐ CD

A cost-based fee will be applied for all copies released directly to patient or authorized legal representative. The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

INFORMATION TO BE RELEASED

I authorize the following PHI to be released from my medical records:

☐ Dates of Service to be released: From: ____/____/____ To: ____/____/____

☐ Abstract/ Pertinent Information	☐ ER Record	☐ History & Physical	☐ Operative/ Procedure Report	☐ Other _____
☐ Consultations	☐ Face Sheet/ Demographic Sheet	☐ Itemized Billing Record	☐ Pathology Reports	_____
☐ EKG/ECG/Cardiac Tests	☐ Discharge Instructions	☐ Lab Reports	☐ Radiology Images	_____
☐ Entire Medical Record	☐ Discharge Summary	☐ MD Progress Notes	☐ Radiology Reports	
		☐ Medication Records		

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

***Required** – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one — Initial each line below

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests & Related Information** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Reproductive Healthcare Services** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Genetic Testing** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Sexually Transmitted / Venereal Diseases** released _____
I ☐ **DO** ☐ **DO NOT** want information about * _____ released

STOP Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if the protected information is not checked and initialed, we may be unable to fulfill this request.

Patient's Signature: _____ **Date:** _____
(Required for all patients 18 years and older. 16 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian: _____ **Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 180 days from the date appearing above . I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation. I understand that under the applicable law the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by Trinity Health Of New England and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. I understand that I may inspect or copy the information that is used or disclosed.

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Of New England

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Trinity Health Of New England Health Information Management Department (formerly, Medical Records) is dedicated to processing your request or inquiry for protected health information in a timely manner. To aid us in fulfilling your request or inquiry please review the listing of frequently asked questions on our company's website at www.trinityhealthofne.org. The Health Information Management hours of operation are Monday through Friday, 8:00 a.m. to 4:30 p.m. and we can be reached at 860-714-4646.

Trinity Health Of New England contracts with MRO (Medical Records Online) Corporation to copy and release medical records. Federal law permits Trinity Health Of New England to charge a reasonable cost-based fee for copies of medical records (reference 45 CFR § 164.524(c)(4)). Federal Law also provides a health care facility 30 calendar days to process a request for medical records. Trinity Health Of New England will aim to process your request within 10-15 business days, depending on the type of records, dates of service requested, and payment of request.

To obtain copies of your record mail or fax the completed authorization form to one of the below entity locations:

Johnson Memorial Hospital, Mercy Medical Center, Saint Francis Hospital, Saint Mary's Hospital and Trinity Health Of New England Medical Group – Connecticut

ATTN: Health Information Management
Trinity Health Of New England
114 Woodland Street
Hartford CT, 06105

Fax: 860-714-8130 – Johnson Memorial Hospital
Fax: 413-748-9809 – Mercy Medical Center
Fax: 860-714-8130 – Mount Sinai Rehabilitation Hospital
Fax: 860-714-8130 – Saint Francis Hospital
Fax: 203-709-3420 – Saint Mary's Hospital
Fax: 1-833-213-5417 – Trinity Health Of New England Medical Group – Connecticut

To follow-up on a status of your request, please call 610-994-7500.