BEAR POND
FAMILY MEDICINE
PEDIATRICS

FRANCINE D YORK, DNP, APRN, FNP-BC

HIPAA AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

Name (First, MI, Last): _____ Date of Birth _____/_____/_____

I, or my authorized representative, authorize disclosure of my Protected Health Information as follows:

BEAR POND FAMILY MEDICINE & PEDIATRICS TO OBTAIN MY MEDICAL RECORDS FROM:
Name of Provider / Office: _____
Address: _____
Phone Number: (_____) _____ Fax Number: (_____) _____

DATES OF TREATMENT COVERED BY THIS RELEASE:

Date(s) of Treatment: _____

☐ **ALL PRIOR DATES OF SERVICE / TREATMENT, THROUGH DISCHARGE FROM PRESENT DATE OF SERVICE / TREATMENT.**

INFORMATION TO BE RELEASED:

☐ All Records
(**Includes** Mental Health, Alcohol / Drug / Substance, Genetic, HIV / Aids, & Medication History)

Initial _____ Alcohol or Drug Use **Initial** _____ HIV Status or Treatment **Initial** _____ Mental Health Information

☐ Progress Notes ☐ History / Physical ☐ Medication Reports ☐ Radiology Reports ☐ Consult Reports

☐ Lab Reports ☐ Discharge Summaries

This information is to be used for the following purpose(s):

☐ Continuing treatment, care and continuity of care ☐ Disability ☐ Transfer of care ☐ Patient Request

☐ Care coordination or case management ☐ Billing, collection or payment of claims ☐ Other: _____

EXPIRATION:

☐ I **do not** want this authorization to expire ☐ This authorization will expire on: _____/_____/_____

PLEASE SEND REQUESTED INFORMATION TO:
BEAR POND FAMILY MEDICINE & PEDIATRICS
55 Hazard Avenue, Enfield, CT 06082
FAX: 860.774.2220

I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Bear Pond Family Medicine & Pediatrics and associated providers to send and/or receive protected health information and that it accurately reflects my wishes.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child

☐ Guardian or conservator of conserved patient

Revised January 1, 2020

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Redisclosure notice to client: If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.

Disclosure notice to recipient of client health care records: You are prohibited from making any further disclosure of client health care records without the specific written authorization of the person who is the subject of such records.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your rights with respect to this authorization:

- *Right to receive copy of this authorization* — You have the right to receive a copy of this authorization.
- *Right to refuse to sign this authorization* — You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization.
- *Right to withdraw this authorization* — You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact our office staff. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- *Right to inspect a copy of the health information to be used or disclosed* — You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting our office staff.
- *HIV test results* — Your HIV test results may be released without your authorization to persons/organizations that have access under Connecticut law and a list of those persons/organizations is available upon request.

55 HAZARD AVENUE ENFIELD, CT 06082
PHONE: 860.744.2244 FAX: 860.744.2220 | WWW.BEARPONDHEALTH.COM