

## Health Record Release

### AUTHORIZATION TO RELEASE, REQUEST, OR OBTAIN CONFIDENTIAL INFORMATION

By signing this authorization, I authorize Kristin Mahan, FNP-C, LLC to use and/or disclose certain protected health information, (PHI), about me to or for the party or parties listed below.

I, \_\_\_\_\_, Date of Birth: \_\_\_\_\_, SSN: \_\_\_\_\_, hereby authorize Kristin Mahan, FNP-C, LLC to  **OBTAIN**  **RELEASE** medical information via, mail, facsimile, or other appropriate source  **TO**  **FROM**:

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**(Person(s) or Entity(s) to receive/release requested information)**

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<b>(Address)</b>	<b>(City, State, Zip)</b>	<b>(Phone number)</b>	<b>(Fax Number)</b>
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I. The individually identifiable health information to be obtained/released is: (Please place a  in appropriate space(s)).

- |                          |   |  |  |
|--------------------------|---|--|--|
| <input type="checkbox"/> | All Records / Information (reports, phone notes, testing, therapy, billing, etc only) |  |  |
| <input type="checkbox"/> | Entire Medical chart (Specify if cover to cover requested)                            |  | <input type="checkbox"/> Therapy notes         |
| <input type="checkbox"/> | X-Ray, Laboratory or other Diagnostic Reports   |  | <input type="checkbox"/> Medication List(s)    |
| <input type="checkbox"/> | Emergency Room Records from _____ (Dates)   |  | <input type="checkbox"/> Financial Information |
| <input type="checkbox"/> | Inpatient Records from _____ (Dates)  |  |  |
| <input type="checkbox"/> | Only the period of events from _____ to _____ (Dates)                                 |  |  |
| <input type="checkbox"/> | Only information related to (Specify) _____   |  |  |
| <input type="checkbox"/> | Other (Specify) _____   |  |  |

Additional information to obtain/release: (Please place a  in appropriate space(s)).

- Psychological Records / Information     Drug / Substance Abuse     HIV results, information
- Alcohol, drug abuse information, etc, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally further release of HIV related information is prohibited without specific authorization.

II. The purpose or need for the disclosure of information:  **Continued Medical Care**  **Legal Case**  **Personal Use**  
 **Other, please explain:** \_\_\_\_\_

III. This authorization will expire on \_\_\_\_\_ (Please indicate expiration date or specific event).  
(If authorization not revoked, and no expiration/event is noted it will terminate 1 year from the date of signature below.)

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to Kristin Mahan, FNP-C, LLC Privacy Officer at 620 Norwich New London Tpke, Uncasville Connecticut 06382.

I understand that this practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I further understand that Kristin Mahan, FNP-C, LLC may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPAA privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release or receipt of the information requested.

\_\_\_\_\_  
(Signature of Patient or Legal Guardian)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Date Signed)

<b>For Office Use Only: Authorization received/verified by:</b> _____ <b>on</b> _____ <b>Copy of Authorization form given to patient</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO / Authorization fulfilled and information sent:</b> _____
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