Day Kimball Medical Group
A community partner of YaleNewHavenHealth

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:** _____

I hereby authorize:

DKMG _____ (Practice Name)	Physician Name:	Phone #:
Street:	City:	State_____Zip _____

To disclose my protected health information to (list below):

Practice Name: _____ Phone: _____
Address: _____ Fax: _____
_____

I understand that my health record may include general information related to the diagnosis/treatment of mental illness, drug/alcohol abuse or other information I may consider sensitive.

The dates of service and type(s) of information to be used or disclosed is as follows:

Date(s) of Treatment:_____

GENERAL RECORDS

- ☐ Discharge Summary ☐ History & Physical ☐ Operative Reports
- ☐ Consultations ☐ Progress Notes ☐ Emergency Room Record
- ☐ Nurses Notes ☐ Laboratory Results ☐ Radiology Reports
- ☐ Pathology Reports ☐ PT/OT/ST Notes ☐ Billings Records
- ☐ Other (please specify): _____

If psychiatric records, substance abuse records or HIV-related information is to be used or disclosed, please indicate specific consent for such disclosure below.

PROTECTED RECORDS

- ☐ Psychiatric Records ☐ HIV Records ☐ Substance Abuse Records

PURPOSE OF RELEASE OF THIS INFORMATION

- ☐ Medical Care ☐ Attorney/Legal Case ☐ Personal Use
- ☐ Disability ☐ Insurance ☐ Workers Comp
- ☐ Other:_____

I UNDERSTAND THAT:

- I may revoke this authorization at any time by providing written notice to DKMG. I understand that I may not be able to revoke this authorization to the extent that DKMG has taken action reliance the authorization.
- This authorization is voluntary. DKMG will not condition treatment, payment, enrollment of eligibility for benefits on my signing this authorization. I am signing this authorization freely, and no one has coerced or pressured me to sign this authorization.
- The protected health information (PHI) under this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- The PHI that is disclosed under this authorization is confidential HIV/AIDS related information, psychiatric or other protected mental health information, or alcohol or drug related information, the recipient may be prohibited from re-disclosing that information under federal of Connecticut state law.

EXPIRATION OF AUTHORIZATION:

This Authorization will Expire on:_____
(Enter a specific date up to one year from today)

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____ _____
Signature of Patient/Parent/Legal Representative* Date Relationship to Patient

*If signing as a legal representative, please provide paperwork to support representative status.