Farmington Pediatric & Adolescent Medicine, LLC
Medical Records Release Request

Patient Information: Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Facility holding your records: I hereby authorize _____

Address: _____ Ph#: _____ Fax#: _____

to release my protected health information to **Recipient:** Farmington Pediatric & Adolescent Medicine

Address: 1 Forest Park Dr. Farmington CT 06032 Ph#: 860-677-1112 Fax#: 860-674-9442

(**FPAM does NOT accept thumb drives or compact disks from other practices**)

A charge of **$0.65 per page** copied is allowable under Connecticut state law and will be charged if Farmington Pediatric & Adolescent Medicine (FPAM) is releasing copies of information from your records other than: **last well-care exam; immunization history; growth chart; allergy, medication & problem lists.**

I request that the information to be disclosed consist of the following: (CHECK ALL THAT APPLY)

- ☐ Lab results
- ☐ X-ray reports
- ☐ Consult reports
- ☐ Hospital reports
- ☐ Complete Medical record of visits with current providers
- ☐ Only most recent physical exam, and immunization record
- ☐ Records from prior providers before current record holder
- ☐ Medication, Allergy and Problem lists

- ☐ I specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcohol or drug abuse) and /or mental health may be disclosed to the above referenced recipients.
- ☐ I do NOT authorize the release of HIV/AIDS. Substance abuse and/or mental health information.
- ☐ This is ONLY the authorization to release psychotherapy notes and cannot be combined with an authorization for use and disclosure for any other type of health information except other psychotherapy notes.

Information to be used/disclosed for the following purpose: _____

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment, HIV/AIDS related information and psychiatric/mental health information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits. I may inspect or copy any information used or disclosed under this authorization.

This authorization will be valid for a period of one year from the signed date below. I understand I may revoke this authorization at any time by notification in writing, but if I do it will not have any effect on actions taken before the revocation was received.

Signature of patient (18yrs & older), or his/her authorized representative, or parent/guardian:

_____ Printed name: _____

Relationship to patient _____ Date: _____