Instructions for the
Authorization for the Release of Information

ECHN
Eastern Connecticut Health Network
The Communities' Choice℠ • www.echn.org

To obtain copies of your medical records:

1. Print the "Authorization for the Release of Information" form (page 2 of this PDF). Please note that the form must be printed as is; we cannot accept forms that have been changed or altered in any way.

2. Complete the form (see instructions below).

3. Mail the form to the Health Information Management Department at the ECHN facility where you were treated. The addresses are at the top of the form.

4. The Health Information Management Department (HIM) will contact you when the records are available to be picked up or forwarded to you. We do our best to complete all requests within 10 business days.

5. If you have any questions, the Health Information Management Department is staffed Monday through Friday, 8 a.m. to 4:30 p.m., at both Manchester Memorial Hospital and Rockville General Hospital. Staff at either location can answer questions.
   - To reach HIM staff at Manchester Memorial Hospital, please call (860) 533-2930, ext. 6433
   - To reach HIM staff at Rockville General Hospital, please call (860) 872-5054, ext. 5664

Completing the form:

Patient Name – Print the name of the patient to whom the medical records pertain.

Patient Date of Birth – Print the patient's date of birth.

Patient Medical Record Number (optional) – If you know the patient's number please print the applicable number.

Purpose or Need for Information Requested – Identify why the information is needed; for example "medical follow up, legal purposes, personal reasons, insurance, moving out of state, etc."

Type of Record – Check off the type of patient visit you are requesting ECHN to release. If not specified, check other and specify the type of information the request pertains to.

Medical Records Are Dated – Indicate the date or the date range of medical records that you are requesting.

Initial Each Type of Information to Release – *Initial* each type of information that you are authorizing ECHN to release. If not specified, check other and specify the type of information the authorization pertains to.

Patient Signature Box – *Only* the patient or the patient's personal/legal representative may sign the authorization form. If the patient's personal/legal representative signs the form (other than the natural or adoptive parent) documentation identifying the individual's legal authority to act as a personal/legal representative for the patient must be included with the authorization form.

Patient Signature – The patient to whom the medical record pertains to must sign and date the authorization.

Signature of Requestor – If the patient is unable to sign the authorization, the patient's personal/legal representative must sign and date the authorization forms. *The signature must be witnessed.*

Print Name of Requestor – Print the name of the personal/legal representative and contact telephone number in case there are questions.

Expiration Date – The authorization will be valid for 12 months unless you specify an earlier date.

Affiliates of Eastern Connecticut Health Network, Inc.

☐ Manchester Memorial Hospital
71 Haynes St., Manchester, CT 06040

☐ Rockville General Hospital
31 Union St., Rockville, CT 06066

☐ Woodlake At Tolland
26 Shenipsit Lake Rd., Tolland, CT 06084

☐ ECHN Health Services, Inc.
71 Haynes St., Manchester, CT 06040

☐ Women's Center For Wellness
2800 Tamarack Ave., S. Windsor, CT 06074

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please PRINT all information

PATIENT NAME (LAST, FIRST) ______________________ **DATE OF BIRTH** ______________ **MEDICAL RECORD # [Optional]** ______________

I HEREBY AUTHORIZE ECHN OR ITS AFFILIATES TO RELEASE INFORMATION TO:

PERSON: ____

FACILITY OR AGENCY: ____

STREET: ____

CITY, STATE, ZIP: ____

PURPOSE OR NEED FOR INFORMATION REQUESTED:

__ **Treatment / follow up care**

__ **Legal**

__ **Insurance**

__ **Other:** ____________________

Unless otherwise specified, only the following information will be released:

- **Inpatient / Surgical** - **History and Physical, Discharge Summary, Consults, Operative Reports**
- **Emergency Dept.** - **ED MD History and Physical**
- **Behavioral Health** - **Discharge Summary**

TYPE OF RECORD: _____ Inpatient _____ Outpatient/Surgical _____ Emergency ____ Other: ____________________________

THE MEDICAL RECORDS ARE DATED: from -__________________ to - __________________

Initial each type of information to release:

_____ Medical/Surgical _____ Laboratory/Pathology _____ Medical Imaging Reports _____Medical Imaging Films
_____ Drug & Alcohol Abuse _____ Mental Health/Psychiatric (excluding Psychotherapy Notes) _____Other: ______________________

MENTAL HEALTH RECORDS – In the event that information released constitutes privileged mental health patient communications, the confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the afore-mentioned statutes.

DRUG AND ALCOHOL ABUSE RECORDS – In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Record regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AIDS OR HIV RELATED INFORMATION: This information has been disclosed to you from records protected by State Law. Connecticut State Law prohibits you from making any further disclosure without the written consent of the patient or as otherwise permitted by said law.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY TREATMENT OR PAYMENT. FURTHERMORE, I UNDERSTAND THAT ONCE INFORMATION HAS BEEN DISCLOSED SUBJECT TO THIS AUTHORIZATION, THE INFORMATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER BE PROTECTED BY STATE OR FEDERAL LAW.

PATIENT SIGNATURE* **DATE**

*If THE PATIENT has NOT SIGNED this form, please indicate the relationship of the signator to the patient:

__ Parent/Guardian __ Administrator/ Executor of Estate __ Power of Attorney/Conservator __ Other (specify):______________________

SIGNATURE OF REQUESTOR: ____________________________ DATE: ____________ WITNESS: ______________________

PRINT NAME OF REQUESTOR: ____________________________ PHONE NUMBER: ____________________________________

THIS AUTHORIZATION MAY BE REVOKED IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT INFORMATION HAS BEEN OBTAINED OR RELEASED. YOUR RIGHTS TO REVOCATION MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES. THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE OF SIGNATURE, OR UPON THE FOLLOWING EARLIER EVENT, CONDITION OR DATE: ____________________________________.