ECHN
Medical Group

2400 Tamarack Avenue, Suite 202
South Windsor, CT 06074
Office Phone: (860) 533-4666
Office Fax: (860) 533-4667

Appointment Date: _____ **Appointment Time:** _____ **Doctor:** _____

Dear Patient:

Thank you for taking the time to complete the attached forms. We have developed this packet to get to know you and your unique medical needs and for you to get to know us as well. **Please arrive 15 minutes prior to your scheduled appointment time and bring a photo ID and your current insurance card.**

Please complete and return the enclosed packet via (mail/fax/bring in to office) BEFORE your scheduled appointment if possible.

We would like you to be aware of a few specific things regarding our office:

1. If you do not call to cancel your appointment 24 hours prior to your appointment, you will be considered a "NO SHOW" and you will be charged a $25.00 No Show fee. After 4 No Shows, you may be discharged from our office.
2. Our office is open Monday – Friday. Please note that we have an answering service and you can leave a message at your convenience if the office is closed.
3. Once you are a patient, please call prescription refills into your pharmacy or take advantage of our Patient Portal to request refills to our office (ask our staff how!) **Please allow 2 business days for your refill requests to get processed.**

Financial Policies and Insurance Information: For routine office visits, co-payment is expected at the time of service. Payment may be made by cash, check, VISA, Discover, Amex, or MasterCard. Our fees are usual and customary and covered by most insurance plans.

Transferring from another Primary Care Provider: Prior to your appointment in our office, we ask that you request a copy of your medical records get sent to our office to ensure that we have your complete medical history.

Referrals: You are responsible for notifying us of any referrals if required by your insurance company.

We look forward to establishing a patient-provider relationship with you that will provide the best possible medical care. If you have any questions, please call us at the telephone number listed above.

Thank you,

EMG Office Staff at South Windsor

Revised 10/16/2018

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PATIENT INFORMATION FORM

Today's Date:

(Please Print Clearly)

❑Mr. ❑Mrs. ❑Miss ❑Ms.	Last Name:				Marital status (circle one) Single / Mar / Div / Sep / Wid
	First Name:	Middle Initial:			
Is this your legal name? ❑Yes ❑No	Former Name:	Birth date: / /	Age	Sex ❑M ❑F	

Email Address:

Street address/city/zip code:

Home phone ( ) : Cell phone ( ) Work phone ( )

Job Title: _____

Employer Name and Address: _____

Employer phone No.: ( ) _____

How did you Hear about our Office (please check one box that is the reason you chose ECMP):

❑ Family*	❑ Friend*	❑ Dr.	❑ Billboard	❑ Sign in Building
❑ CT Top Docs	❑ Hospital	❑ Seminar	❑ Radio	❑ Insurance Plan
If Online please mark source	❑ ECHN Website	❑ Twitter	❑ Google Search	❑ Other – Please Note

*If referred by patient, may we thank them for referring you to our office?

❑ YES ❑ NO If Yes, Name:_____

Other Family Members that are Patients of our office: (Optional):

EMERGENCY CONTACT: Name_____ Relationship _____ Phone(s) _____

CENSUS INFORMATION

RACE	Primary Race	Non-primary Race
American Indian or Alaskan Native	❑	❑
Asian	❑	❑
Black or African American	❑	❑
Native Hawaiian or Other Pacific Islander	❑	❑
White	❑	❑
Other	❑	❑
Decline to answer	❑	❑

ETHNICITY: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Other ❑Decline to answer

PREFERRED LANGUAGE:

MUST COMPLETE – REQUIRED

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians of Eastern CT Medical Professionals. I understand that I am financially responsible for any balance, including my policy deductibles and co-insurances. These are required payments by my insurance company, not ECMP. I authorize ECMP or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature *Date*

ECHN Medical Group

Patient Name:_____ Date of Birth:_____

MEDICAL HISTORY

Please review all of the following:

Problem		Years	Problem		Years	Problem		Years
Asthma	❑Yes ❑No		Hyperthyrodism	❑Yes ❑No		Urinary Incontinence	❑Yes ❑No	
COPD	❑Yes ❑No		Hypothyroidism	❑Yes ❑No		Blood Clots	❑Yes ❑No	
Obstructive Sleep Apnea	❑Yes ❑No		Gout	❑Yes ❑No		Deep Vein Thrombosis (DVT)	❑Yes ❑No	
Pulmonary Embolism	❑Yes ❑No		PCOS	❑Yes ❑No		Anemia	❑Yes ❑No	
Hypertension/High Blood Pressure	❑Yes ❑No		Infertility	❑Yes ❑No		Other Blood Disorders	❑Yes ❑No	
Chest Pain/Angina	❑Yes ❑No		Irregular Menstrual Cycle	❑Yes ❑No		Anxiety	❑Yes ❑No	
Palpitations/ Arythmias	❑Yes ❑No		Reflux/Heartburn	❑Yes ❑No		Depression	❑Yes ❑No	
Coronary Artery Disease/CAD	❑Yes ❑No		Stomach Ulcers	❑Yes ❑No		Bipolar Disorder	❑Yes ❑No	
Peripheral Vascular Disease/PVD	❑Yes ❑No		Peptic Ulcer Disease	❑Yes ❑No		Binge Eating Disorder	❑Yes ❑No	
Heart Attack/ Myocardial Infarction/MI	❑Yes ❑No		Crohn's Disease	❑Yes ❑No		Anorexia	❑Yes ❑No	
Swollen Legs/ Edema	❑Yes ❑No		Ulcerative Colitis	❑Yes ❑No		Bulemia	❑Yes ❑No	
Stroke/CVA	❑Yes ❑No		Fatty Liver Disease	❑Yes ❑No		Schizophrenia	❑Yes ❑No	
TIA/mini-stroke	❑Yes ❑No		Gallbladder Disease	❑Yes ❑No		Other Psychiatric Disorders	❑Yes ❑No	
Diabetes	❑Yes ❑No		Kidney Disorders	❑Yes ❑No		Arthritis	❑Yes ❑No	
Pre-Diabetes	❑Yes ❑No		Kidney Stones	❑Yes ❑No		Joint Pain	❑Yes ❑No	

History of Cancer: ❑ No ❑ Yes

If YES, please list the type of cancer and the treatment that you received:

_____

_____

HOSPITALIZATIONS for Medical Problems (please include any hospitalizations for Mental Illness)

Hospital Name	Reason for Stay	Date

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Patient Name:_____ Date of Birth:_____

PREVIOUS SURGERY			
Surgery	**Year**	**Purpose**	**Complications**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

MEDICATIONS

PREFERRED PHARMACY/LOCATION: _____

Pharmacy Phone number: _____ Pharmacy Fax number: _____

Medication Name	**Dose**	**Times per Day**	**Purpose**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

Please check if you take any of the following: ❑ Aspirin ❑ Coumadin ❑ Plavix ❑ Other Anti-Platelet ❑ Other Blood Thinners

Please check if you take any of the following:

❑ Multi-Vitamin ❑ Vitamin A, D, E combo ❑ Calcium ❑ Calcium with Vitamin D ❑ Vitamin D ❑ Iron ❑ Vitamin B12Do you take prophylactic antibiotics prior to any procedures? ❑ No ❑ Yes (If YES, why?) _____

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Patient Name:_____ Date of Birth:_____

MEDICATIONS (Continued)

Do you have diabetes? ❑ No ❑ Yes
If YES, then please respond to the following questions. If NO, then proceed to the next section.

How many years have you had diabetes? _____	How do you control your diabetes? ❑ Dietary Intake ❑ Oral Medications ❑ Insulin
Do you see a specialist for your diabetes? ❑ No ❑ Yes If YES, who do you see? _____	How often do you check your blood glucose? _____
Do see a Podiatrist (Foot Doctor)? ❑ No ❑ Yes	Have you seen an Ophthalmologist (Eye Doctor)? ❑ No ❑Yes
How long have you been on medication for diabetes? ❑ Oral Medications (metformin, actos): _____ years ❑ Non-insulin injections (Victoza, Byetta): _____ years ❑ Insulin: _____ years	What is you last Hgb A1C? _____ When was your last blood work done? _____

Have you been Hospitalized for Diabetes in the past year? ❑ No ❑ Yes
If YES, what was the reason
_____
_____

Do you have any of the following:	❑ Nerve Damage (Neuropathy)	❑ Eye Damage (Retinopathy)	❑ Kidney Damage (Neprhopathy)
	❑ Diabetic Ketoacidosis (DKA)	❑ Gastroparesis	❑ Vascular Disease
	❑ Foot Infections	❑ Amputations	❑ Heart Disease (CAD)

Have you ever attended a Diabetic Education Class? ❑ No ❑ Yes
If YES, where and when did you attend this class? _____

What is the most difficult part of taking care of your diabetes?
_____
_____

ALLERGIES

Medication	Allergic Reaction	Medication	Allergic Reaction
1.		4.	
2.		5.	
3.		6.	

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No If NO, have you ever smoked? ❑ Yes ❑ No, When did you quit? _____	How many cigarettes/day? _____ How many years have been smoking? _____ Have you ever quit? ❑ Yes ❑ No (If Yes, when? _____)
Do you drink alcohol? ❑ Yes ❑ No	How much do you drink at one time? _____ What type of alcohol do you drink? _____ How often do you drink a week? _____
Do you use any recreational drugs? ❑ Yes ❑ No	What type of drugs do you use? _____ How often do you use drugs? _____
Have you been in drug/alcohol treatment? ❑ Yes ❑ No	If YES, dates of treatment: _____
How many children do you have? _____	Please list their ages: _____

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Patient Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS				
General	❑ Fevers	❑ Chills	❑ Fatigue	❑ Insomnia
	❑ Stress	❑ Weakness	❑ Recent Weight Gain	❑ Recent Weight Loss
	Comments:			
Eyes, Ears, Nose & Throat	❑ Glasses/Contacts		❑ Blurred Vision	❑ Double Vision
	❑ Hearing Loss		❑ Ringing in Ears	❑ Ear Aches
	❑ Nose Bleeds		❑ Sore Throat	❑ Hoarseness
	❑ Dental Problems		❑ Dentures	
	Comments:			
Heart and Blood Vessels	❑ Chest Pain		❑ Palpitations	❑ Irregular Heartbeat
	❑ Shortness of breath with Activity		❑ Shortness of breath when lying down	❑ Swelling in Ankles/Feet
	❑ Fatigue		❑ Heart Failure	❑ Pain in Calves when Walking
	Comments:			
Lungs	❑ Wheezing		❑ Snoring	❑ Sleep Apnea
	❑ Shortness of breath		❑ Chronic Cough	❑ Coughing up Blood
	❑ COPD/Emphysema		❑ Respiratory Failure	
	Comment:			
Gastrointestinal	❑ Loss of Appetite		❑ Nausea	❑ Vomiting
	❑ Vomiting Blood		❑ Reflux/Heartburn	❑ Difficulty Swallowing
	❑ Pain when Swallowing		❑ Abdominal Pain	❑ Bloating
	❑ Diarrhea		❑ Constipation	❑ Change in Bowel Habits
	Comments:			
Genitourinary	❑ Frequent Urination		❑ Urgency to Urinate	❑ Painful Urination
	❑ Blood in Urine		❑ Change in Urine Stream	❑ Urinary Retention
	❑ Urinary Incontinence		❑ Recurrent UTIs	❑ Venereal Disease
	Comments:			
Musculoskeletal	❑ Joint Pain		❑ Joint Swelling	❑ Muscle Weakness
	❑ Neck Pain		❑ Back Pain	❑ Limited Range of Motion
	❑ Require a cane/walker		❑ Arthritis	
	Comments:			
Hematologic / Lymphatic	❑ Swollen Glands		❑ Lymph nodes	❑ Fevers
	❑ Night Sweats		❑ Blood Clots	❑ Bleeding Disorders
	❑ Bruising		❑ Slow to Heal after Cuts	❑ Blood Transfusions
	Comments:			
Skin and Breast	❑ Rashes		❑ Itching	❑ Change in Skin
	❑ Change in Nails		❑ Loss of Hair	❑ Breast Pain
	❑ Breast Lump		❑ Nipple Discharge	❑ Nipple Bleeding
	Comments:			
Neurologic	❑ Frequent Headaches		❑ Light Headed	❑ Dizziness
	❑ Tremors		❑ Numbness	❑ Tingling
	❑ Loss of Vision		❑ Seizures	❑ Head Trauma
	Comments:			
Endocrine	❑ Excessive Thirst		❑ Excessive Hunger	❑ Excessive Urination
	❑ Heat Intolerance		❑ Cold Intolerance	❑ Goiter
	Comments:			
Psychiatric / Mental	❑ Memory Loss		❑ Confusion	❑ Anxiety
	❑ Nervousness		❑ Loss of Sleep/Insomnia	❑ Depression
	❑ Hallucinations		❑ Suicide Attempts	❑ Homicidal Ideations
	Comments:			
Immune	❑ Immunosuppression		❑ Transplant	❑ HIV/AIDS

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Patient Name:_____ Date of Birth:_____

PSYCHOLOGICAL HISTORY		
Have you been treated or hospitalized for an emotional disorder? ❑ No ❑ Yes If YES, please explain: _____	❑ In the Past	❑ Currently
Do you have suicidal thoughts on a regular basis or made a suicide attempt? ❑ No ❑ Yes If YES, please explain: _____	❑ In the Past	❑ Currently
Have you received treatment for drug or alcohol abuse (impatient or outpatient)? ❑ No ❑ Yes If YES, please explain: _____	❑ In the Past	❑ Currently
Have you been treated for an eating disorder (anorexia, bulimia, binge eating disorder, or compulsive overeating? ❑ No ❑ Yes If YES, please explain: _____	❑ In the Past	❑ Currently
Have you been placed on disability or lost a job for an emotional or nervous disorder? ❑ No ❑ Yes Have you been treated or hospitalized for an emotional disorder? ❑ No ❑ Yes	❑ In the Past	❑ Currently
Have you been in any relationships that you or others would consider abusive? ❑ No ❑ Yes If YES, please explain: _____	❑ In the Past	❑ Currently

FAMILY HISTORY		
Family History: (Please check off any of which apply and list the family member(s) affected)		
❑ Diabetes	❑ High Blood Pressure	❑ Cancer
❑ Sleep Apnea	❑ High Cholesterol	❑ Heart Disease
❑ Obesity	❑ Arthritis	❑ Depression
❑ Bleeding Disorders	❑ Blood Clots	❑ Reaction to Anesthesia
❑ Other		

	Alive or Deceased	Reason for Death
Mother		
Father		
Siblings		

FINAL SIGNATURE - REQUIRED

I attest that if have completed the above medical form. All the above information is true to the best of my knowledge. I understand that the physicians at ECMP will utilize the information to develop and deliver the best treatment plan for me. Any false or inaccurate information may lead to an unexpected outcome and injury to myself. I also authorize ECMP to discharge me from the practice if I provide false or inaccurate information.

_____ _____

Patient/Guardian Signature *Date*

ECHN Medical Group

HIPAA PRIVACY RESTRICTION QUESTIONNAIRE

Patient Name _____ Date of Birth _____

Address, City and State _____

Home Phone _____ Cell Phone: _____

Work Phone _____ Email address: _____

Do you have an Advance Directive? (If yes, please bring a copy to your next appointment.)	Yes	No
Do you have a Living Will (If yes, please bring a copy to your next appointment.)	Yes	No

Where may we call you?	Home	Work	Cell
Where can we leave messages including lab results?	Home	Work	Cell
May we text you?	Yes	No	N/A
May we email you?	Yes	No	

Unless otherwise specified statements and reminder cards will be sent to your home address.

May we speak to your spouse or significant other regarding your treatment? Yes No N/A

Name _____ Relationship _____ Phone number _____

May we speak to another family member regarding your treatment? Yes No

Name _____ Relationship _____ Phone number _____

Emergency Contact

Name: _____ Phone number: _____ Relationship: _____

_____ _____

Signature of Person Granting Authorization **Date**

Relationship to Patient: Self / Parent / Guardian / POA / Other _____

Pediatric Patients: Call Mother Only Call Father Only Call Either Parent

Names of all children that apply to these restrictions:

_____ _____

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Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by ECHN Medical Group to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by ECHN Medical Group may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how my information will be used and disclosed can be found in the Notice of Privacy Practices. I understand that this consent is effective for as long as ECHN Medical Group maintains my protected health information.

Communication Consent- Phone Calls and Text Messages

It is understood and agreed that ECHN Medical Group and/or its authorized agents may contact me, or a representative I appoint, using any contact or cell phone numbers I provide to it, or that may be available by any other means. I expressly agree that ECHN Medical Group may contact me at such numbers by telephone, pre-recorded voice messages and text messages, and may use an automatic telephone dialing system and/or an artificial pre-recorded voice.
This express authorization applies even if I am charged for the call under my mobile phone plan. I agree that such contact will not be "unsolicited" for purposes of local, state or federal law. I further agree that ECHN Medical Group and/or its authorized agents may monitor and/or record any communication with me.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I can ask for and receive ECMP's Notice of Privacy Practices currently in effect.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual:

_____

Unable to obtain written consent and acknowledgment because:

☐ Individual refused ☐ Emergency treatment situation ☐ Individual not able to sign due to incompetence or other medical reason ☐ Other: _____

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Medical Group

In order to for ECHN Medical Group (EMG) to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to ask any questions you may have.

- You must pay any co-payment and applicable deductible amounts due at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express. There will be a $12.00 charge for all returned checks. Fee is subject to change without notice.

- If you are not insured, or if the services are not covered by your insurance, you are expected to provide full payment at the time they are rendered. EMG has income based financial assistance paperwork that will be given upon request.

- EMG will bill your insurance company as a courtesy. Please understand that the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductibles and any services that are not covered by your insurance plan.

- If, by mistake, your health plan remits payment to you, please deposit the check from your insurance company and send a personal check to our billing company along with all paperwork received from your insurance company. Mail check and paperwork to.

ECHN Medical Group
1801 W. Olympic Blvd File 2201
Pasadena, CA 91199-2201

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- Your health plan may refuse payment of a claim for some of the following common reasons. This is not an all-inclusive list; please check with your insurance company should you have any questions.
    - This is a pre-existing illness that is not covered by your plan.
    - You have not met your full calendar year deductible.
    - The type of medical service required is not covered by your plan.
    - The health plan was not in effect at the time of service.
    - You have other insurance which must be filed first.

- Appointments cancelled with less than 24 hours' notice may incur a $25.00 fee.
    - This excludes Medicare and Medicaid patients.
    - Multiple "No Show's" are subject to EMG'S discharge policy.

- Patient balances not paid after 90 days may be sent to a collection agency. Unpaid outstanding balances are subject to EMG's discharge policy.

- EMG may charge $5.00 per form to be completed outside of an office visit.
    - All forms have a 5 business day turn-around

I have read and understand my obligations and I acknowledged that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

_____ _____ _____

Signature of Patient Printed name of Patient DOB

_____

Date

ECHN Medical Group

ECHN MEDICAL GROUP
2400 Tamarack Ave Suite 202 South Windsor, CT 06074
Phone 860-533-4666 Fax 860-533-4667

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

No part of this authorization is a required field. However, it is requested to assist ECHN in fulfilling your request accurately. There may be a reasonable, cost-based fee that complies with both federal and state regulations, associated with this request.

1. Patient Information

NAME *(Last, First, Middle Initial)*		**MAIDEN/OTHER NAME**
DATE OF BIRTH	**PREFERRED PHONE NUMBER** ( )	**ARE YOU A VETERAN?** ☐ YES ☐ NO

2. Release To/Obtain From

I HEREBY AUTHORIZE ECHN TO: ☐ Release Information **TO** ☐ Obtain Information **FROM**

NAME OF PERSON OR INSTITUTION	**PHONE NUMBER** ( )	**FAX NUMBER** *(Healthcare Providers Only)* ( )

MAILING ADDRESS *(Number/Street/Apartment No./PO Box)* *(City/Town)* *(State)* *(Zip Code)*

FORM/FORMAT
I request that the information be provided in the form/format outlined below where possible/available:
☐ Paper ☐ Electronically on CD/disc/flash drive ☐ Other (Please Specify):

METHOD OF DELIVERY
☐ Mail ☐ Verbal ☐ Pick-Up Onsite *(Photo-ID Required)* ☐ Fax *(Healthcare Providers Only)*
☐ By Unencrypted E-mail to This Email Address**: _____ *(Initial)* _____
*** I am requesting my protected health information be delivered in an unencrypted format. I understand and accept all risks associated with releasing my medical record information using unencrypted electronic formats, including access by an unintended third party.*

3. Information Request

DATE(S) OF SERVICE FROM: _____ **to** _____

TYPE OF INFORMATION TO BE RELEASED OR OBTAINED *(Check One or More)*
☐ Medical/Surgical Report(s) ☐ Behavioral Health *(initial below)* ☐ Laboratory/Pathology Report(s)
☐ History & Physical/Consult Record(s) ☐ Imaging Report(s) ☐ Entire Record

Other Information *(Please Specify)*: _____

If any of the above information being requested contains the following sensitive information, please initial.
AIDS/HIV Information: _____ *(Initial)* **Drug/Alcohol Information:** _____ *(Initial)* **Mental Health Information:** _____ *(Initial)*

PURPOSE *(Optional, Access Will Not Be Denied Based On Providing This Information)*
☐ Patient or Legal Representative ☐ Other Healthcare Providers ☐ Supporting a Claim/Appeal ☐ Legal
☐ Other *(Please Specify)*:

4. Authorization

AUTHORIZATION EXPIRES *(If no expiration given, authorization will expire twelve (12) months from the signature date)*
☐ ONE (1) Year From Date of Authorization **OR** ☐ Other Date *(Please Specify)*: ____/____/_____

I hereby authorize Eastern Connecticut Health Network or its wholly owned affiliates (collectively "ECHN") to release, disclose or obtain the records described above for such purposes described above. I understand the following:

- *I have the right to cancel (revoke) this authorization in writing to the respective Health Information Management Department or Privacy Officer, at any time. My rights to revoke this authorization can be found in ECHN's Notice of Privacy Practices. Cancellation of the authorization will not apply to information that has already been released or disclosed based upon this authorization.*
- *This authorization is voluntary; my treatment at ECHN is in no way conditioned on whether or not I sign this authorization.*
- *If the recipient of the information is not a healthcare provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above is no longer protected by the Privacy Rule and may be re-disclosed by the recipient.*

Patient Signature ***(Please let a Health Information Management Associate know if assistance is needed, or if unable to sign form)***

Patient Print Name X	**Patient Signature** X	**Date/Time**

Requestor Other Than Patient

If the patient has not signed this form, please indicate the relationship of the requestor to the patient:
** You **MUST** attach proof of your authority to act on behalf of the patient as checked below (other than parent).*
☐ Parent ☐ Legal Guardian ☐ Healthcare Representative ☐ Conservator ☐ Executor/trix of Estate ☐ Power of Attorney
☐ Other *(Please Specify)*:

Requestor Print Name X	**Requestor Signature** X	**Date/Time**

ECHN Medical Group

ECHN MEDICAL GROUP
2400 Tamarack Ave Suite 202 South Windsor, CT 06074
Phone 860-533-4666 Fax 860-533-4667

PROHIBITIONS ON REDISCLOSURE NOTICE

AIDS OR HIV RELATED INFORMATION

In the event that information released constitutes confidential AIDS/HIV related information protected under Connecticut Law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by federal and state 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 the 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.

MENTAL HEALTH TREATMENT INFORMATION

In the event that the information released constitutes privileged psychiatrist-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 consent or other authorization as provided in the aforementioned statutes.

STATEMENT OF NONDISCRIMINATION AND AVAILABILITY OF COMMUNICATION SERVICES English:

ECHN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English or any of the languages below, language assistance services, free of charge, are available to you. Call 1-860-646-1222.

Español (Spanish): ECHN cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-646-1222.

Polski (Polish): ECHN postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć. UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-646-1222.

Copy to Medical Record
Copy to Patient/Representative