

Authorization for Access/Release of Information

Legal Name: (Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: Phone: Email:

Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: Personal use Continuing care Legal Disability Workers Comp Insurance Eligibility/Benefits Social Security Card Other

I hereby authorize Yale New Haven Health/Yale Medicine entity(ies) named below to:

RELEASE information from my medical record TO: OBTAIN information FROM:

Name: Phone:

Address: City/State: Zip Code:

Fax (optional): Email (optional):

If medical records are being requested from an external provider/facility for patient care at YNHHS, please provide name of YNHHS location to send medical information:

YNHHS Provider Name:

Complete Address:

Fax Number: Phone Number:

Method of Disclosure: MyChart (Must have active account) Mail Fax Secure Email Pick-up Please indicate how you would like to be contacted when ready for pick-up:

Visit Type: Admission Outpatient Surgery Emergency Dept. Visit Physician Office/Clinic Other

Location: Yale New Haven Hospital (York Street Campus/St. Raphael's Campus/Smilow Care Centers)

Bridgeport Hospital (includes Milford Campus after 6/8/2019) Milford Hospital (prior to 6/9/2019) Greenwich Hospital

NEMG Provider Practice Name:

Yale Medicine Provider Practice Name:

Date(s) of Service:

Medical Information Requested:

Abstract of Medical Record (History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

- History & Physical Exam/HP Lab Results Stress Test Consult Report
Discharge Summary/DS Radiology Report Echocardiogram/EKG Clinic/Office Notes
Emergency Visits/ED Pathology Report Pulmonary Function Test Medication List
Operative/Procedure Report Immunization Record PT/OT/Speech Notes Other

Complete Medical Record (Includes all of the above, plus nursing notes, ancillary notes, and consents. Excludes nursing flowsheets unless specifically requested).

Itemized Bill Radiology Image(s):

Please note date and type

Reasonable cost-based fees apply.



HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. (Medical records containing any of the protected information below must also be signed by the patient if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if a minor age 16 or older.)

Indicate which you do NOT want released with your initials:

___ HIV ___ Substance Abuse (which includes Alcohol & Drug Abuse) ___ Pregnancy Test ___ Genetic Testing
___ Behavioral Health/Psychiatric ___ Sexually Transmitted Disease ___ Other (please list) _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing YNHHS Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by YNHHS/Yale Medicine is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol information is included for a patient age 13 or older, the minor must sign as described above.

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: Yale New Haven Health
Health Information Management
Release of Information Services
PO Box 9565
New Haven, CT 06535

YNHHS Hospital(s) Fax Number:	203-688-4645	Email to: releaseofinfo-Hosp@ynhh.org
NEMG Provider Fax Number:	203-200-1286	Email to: releaseofinfo-NEMG@ynhh.org
YM Provider Fax Number:	203-200-1287	Email to: releaseofinfo-YM@ynhh.org

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 203-688-2231.

Printed Name: _____ Date: _____

Signature of Patient or Authorized Representative

***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

- Self Parent Legal Guardian Executor/Administrator of Estate Healthcare Representative Conservator
 Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)	Signature of Minor (when applicable)	Date
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