ADVANCED ORTHOPEDICS NEW ENGLAND

□ Hartford/Rocky Hill: P (860) 728-6740 F: (860) 547-1554
□ Bloomfield : P: (860) 242-3000 F: (860) 286-9547
□Enfield: P: (860) 253-0276 F: (860) 253-0431
□Springfield, MA: P: (413) 788-7321 F: (413) 733-6369

# AUTHORIZATION TO DISCLOSE & TRANSFER PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth _____ SS# _____

Address: _____Phone _____

I _____, the patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information unless directed otherwise below.

**FILL OUT FOR AONE TO DISCLOSE**

I authorize Dr._____
To disclose health information to:
Name _____

Facility_____

Address_____

_____

Telephone: _____

Fax: _____

**FILL OUT FOR AONE TO OBTAIN**

I authorize _____
to disclose health information to:
**Advanced Orthopedics New England**

1000 Asylum Avenue #2126

Hartford, CT 06105

Contact Person _____

(see contact phone and fax above)

**Records copying fee will be incurred for all medical records requests over 25 pages. Detail of State Rates: $0.65 per page. There will be no charge for any requests related to Social Security. Proof of documentation for claim required. Copy of X-Ray/MRI: $5.00 per CD**

The purpose for which this disclosure is to authorize (CIRCLE where applicable):

Medical Care Insurance Attorney Personal Government Other_____

This authorization will expire on: _____/_____/_____ (fill in date if less than 1 year) or 1 year after being signed.

Authorized Data: I request that the information to be used or disclosed consists of the following: Check all that apply.

Billing _____ Chart Notes _____ Radiology _____ Hospital/Surgery _____ Entire Record _____

Records to include dates of service: from: _____ to: _____

This form serves as a release of protected health information for specific information authorized as noted above protected by State and Federal confidential laws and regulations. The information released may contain information pertaining to psychiatric, psychological, drug and/or HIV/AIDS testing and/or treatment, UNLESS noted below

**DO NOT RELEASE**: _____ **Mental Health**_____ **Substance abuse**_____ **HIV/AIDS**_____

I understand authorizing the disclosure of this health information is voluntary and I must be provided a copy of this form if I choose to sign it. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or copy the information to be used or disclosed according to State and Federal Law, and as stated in the privacy notices of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential of unauthorized re-disclosure. I understand if I revoke this authorization I must do so in writing and present it to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Patient/Personal Representative (e.g. legal guardian) Signature:** _____ **Date:** _____

**Print Name:** _____ **Representative's Relationship:** _____