



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name: _____ DOB: _____ MR # _____

By signing this form, I (the patient or legal representative) authorize Starling Physicians to either send/ obtain a copy of my (or my child's) medical records.

Send records from:

Physician/Provider Name:	Telephone:
Address:	Fax:

Send records to:

Physician/Provider Name:	Telephone:
Address:	Fax:

Relationship to patient: Patient Parent Guardian Legal Representative Other: _____

Minor child's Name: _____ DOB: _____

I authorize the following PHI (Protected Health Information) be sent for the sole purpose of: (Select option below)

* Transfer of Care Second Opinion Relocation Other _____

*For transfers of care, I understand that my patient/physician relationship will be terminated 30 days from the date of my signature and that I will no longer be considered an active patient.

The dates of service and type(s) of information to be disclosed shall include: (please check the appropriate boxes below)

Provider _____ Specialty _____ Location _____

Include only the following specified information/records from the medical record:

- History & Physical Operative Reports Pathology Reports Consultations Progress Notes
- PT/OT/ST Notes Laboratory Results Radiology Reports Radiology Films Billing Records
- Psychotherapy Notes (If this box is checked, no other information may be requested in the Authorization)
- Other (please specify): _____

Dates of treatment covered by this release: All dates, or Limited to the following dates: _____

All medical records and information/records received from other health care providers.

Psychotherapy notes will not be included unless you provide separate authorization by initialing here ____.

I understand that state law prohibits the use and/or disclosure of the following types of PHI below without specific authorization by me. I indicate my authorization to release this information by initialing next to each option selected below:

- Genetic Testing ____ HIV (AIDS) related information ____ Drug and/or alcohol abuse treatment information ____
- Sexual transmitted disease information ____ Sexual abuse/assault and domestic violence records ____
- Mental health records ____ Psychiatric Information ____

My rights regarding this authorization: I understand that this permission form is only good for one year from the date I sign it, unless I indicate a different date here: _____.

I may cancel my permission at any time by writing a letter to cancel this permission or signing the cancellation below and sending it to Starling Physicians PC, Attention: Privacy Officer at 2110 Silas Deane Highway, Rocky Hill, CT. I understand that Starling Physicians, PC may have already sent my records prior to receiving my cancellation. Further, I understand that my medical treatment will not be affected if I do not sign this form. I understand that I may look at my medical records or receive a copy before they are sent. I further understand that this consent does not protect my personal health information from being disclosed by the receiving party. According to state law, I will be charged a copy fee of .65¢ per page when applicable. My signature below indicates that I have read and understand this Authorization and its terms.

Patient Signature or *Legal Representative

*Provide legal documentation

Date

Cancellation of Authorization:

Signature of Patient or *Legal Representative

Date