Yale HEALTH

Health Information Management Yale Health, PO Box 208237 New Haven, CT 06520-82327
Fax: 203-436-5536
yhmedicalrecords@yale.edu

Authorization for Use or Disclosure of Protected Health Information

Legal Name: _____ _____ ___ _____
(Last) (First) M.I. Preferred Name

Date of Birth: _____ **Phone:** _____ **Email:** _____

_____

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

This disclosure is at the request of the patient or for ☐ Person ☐ Medical Care ☐ Legal ☐ Workers Comp ☐ School ☐ Other

I hereby authorize Yale University to (choose one):

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

Name: _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Fax (optional): _____ **Email** (optional): _____ **Phone:** _____

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
☐ Discharge Summary/DS
☐ Emergency Visits/ED
☐ Operative/Procedure Report
☐ Outpatient Visit Notes
☐ Lab Results Radiology
☐ Report Pathology
☐ Report Immunization
☐ Record
☐ Stress Test
☐ Echocardiogram/EKG
☐ Pulmonary Function Test
☐ PT/OT/Speech Notes
☐ Consult Report
☐ Clinic/Office Notes
☐ Medication List
☐ Prescription Billing
☐ Itemized Claims Billing

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

☐ Radiology Image(s): _____
Please note date and type

Delivery Method (choose only one): ☐ MyChart (Must have active account. To activate your account go to mychart.ynhhs.com)

☐ Certified Mail ☐ Fax (Number: _____) ☐ Secure Email ☐ Pick-up/Hand carry

I understand that this health information may include sensitive information. HIV related-information and Substance Abuse Treatment records require your specific consent for release. Indicate which you are consenting to be released by selecting the appropriate option AND providing you signature autorizing your consent:

☐ HIV ☐ Substance Abuse (includes Alcohol & Drug Abuse) ☐ Behavioral Health/Psychiatric
☐ Termination of Pregnancy ☐ Sexual Transmitted Disease ☐ Genetic Testing

I understand that:

- this authorization will expire on or one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.
- I may revoke this authorization at any time by notifying the Privacy Officer,verbally or in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. Send revocation to: HIPAA Privacy Officer, Yale University, PO Box 208252, New Haven, CT 06520-8252.
- information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected 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.
- my health care and payment for my health care will not be affected if I do not sign this form.
- my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- upon request, I may receive a copy of this form after I sign it.
- 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 below.

By signing below, I acknowledge that I have read and understand this Authorization.

Sign Here: _____ Date _____

Relationship to Patient: **Patient /Parent/Legal Guardian/Authorized Person**

Printed Name of Minor (if applicable) _____

Signature of Minor (if applicable) Date_____

For records requested to be sent to Yale, please send records to: Yale Health, P.O. Box 208237, New Haven, CT 06520- 8237 or fax to 203-436-5536 or email to yhmedicalrecords@yale.edu.