OPTIMUS HEALTH CARE

Office Use Only	
Patient Name:	
Chart Number	
Date	

Health Information Department
982 East Main Street
Bridgeport, CT 06608
(P) 203-621-3857 (F) 203-683-3612

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

****Please read and complete all items****

Patient Name:		Alias/Maiden Name:
DOB:	Last 4 SSN:	Phone:
Address:		

I authorize the use/disclosure of health information about me as described below:

☐ To obtain from: _____ (release from what organization)	☐ To disclose to: _____ (release to whom)
Address: _____ _____	Address: _____ _____

I authorize the disclosure of following information from my health record

☐ MEDICAL ☐ BEHAVIORAL/MENTAL HEALTH (other than psychotherapy notes) _____ ***(initials)***

☐ DENTAL

Please specify visit dates From _____ To _____

☐ Complete medical record
☐ Individual results (Please Specify) _____
☐ Physician office notes
☐ Imaging files and/or CD's
☐ Billing statement
☐ Other (Please Specify)_____

For the purpose of:

☐ Further medical care	☐ Personal	☐ Insurance eligibility/benefits
☐ Changing Physicians	☐ Legal Investigation	☐ Billing inquiries
Other:		

I understand that the information in my health record may include information relating to sexually transmitted infections, AIDS, or HIV. It also may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below and ***signing your initials as secondary acknowledgment.***

☐ _____ ***(initials)*** I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R §§2.34 and 2.35).

☐ _____ ***(initials)*** I specifically authorize the release of the HIV and AIDS test results (Health and Safety Code §19a-589.

☐ _____ ***(initials)*** I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

How do you want to receive your records? □ CD or □ PAPER
NOTICE

Optimus Health Care Inc. and many other organizations and individuals such as physicians, hospitals and health plans are legally required to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to Release Health Information ("Authorization") is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment; (2) to obtain information in connection with eligibility or enrollment in a health plan; (3) to determine an entity's obligation to pay a claim; or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Optimus Health Care Inc. Health Information Department, 982 East Main St., Bridgeport CT, 06608. The revocation will take effect when Optimus Health Care Inc. receives it, except to the extent Optimus Health Care, Inc. or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization ***will expire 12 months after the date of signing*** this form.

Patient/Parent/Guardian Signature:	Date:
Patient/Parent/Guardian Printed Name:	Date:
Witness (only if Patient is unable to sign) or Interpreter	Date:

If patient is unable to consent or is a minor, complete the following:
If signed by a person other than the patient, select relationship. Legal documentation may be required.

Patient is:	☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal authority: (Please circle)	Legal guardian Custodial parent Power of attorney for healthcare (if executed prior to October 1, 2006) Executor of Estate of Deceased Authorized legal representative

Note: My signature acknowledges that I or my representative received a copy of this Authorization. This Authorization will not be accepted unless it is completed in its entirety. A copy of this Authorization will be accepted in lieu of an original.