MANCHESTER MEMORIAL HOSPITAL
71 HAYNES ST., MANCHESTER, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 UNION ST., ROCKVILLE, CT 06066

Affiliates of Eastern Connecticut Health Network, Inc.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please PRINT all information.

PATIENT NAME (LAST, FIRST) DATE OF BIRTH	MEDICAL RECORD # [Optional]

I HEREBY AUTHORIZE MANCHESTER MEMORIAL AND/OR ROCKVILLE GENERAL HOSPITALS TO RELEASE INFORMATION TO: PERSON	I HEREBY AUTHORIZE MANCHESTER MEMORIAL AND/OR ROCKVILLE GENERAL HOSPITALS TO OBTAIN INFORMATION FROM: PERSON
FACILITY OR AGENCY **RECORDS DEPOSITION SERVICE, INC.**	FACILITY OR AGENCY
STREET **PO BOX 5054**	STREET
CITY, STATE, ZIP **SOUTHFIELD, MI 48086-5054** **T-248.357.3330 F-248.357-3337**	CITY, STATE, ZIP

PURPOSE OR NEED FOR INFORMATION REQUESTED: FOR DISCOVERY BEFORE TRIAL ______________________

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TYPE OF RECORD: ____ Inpatient ____ Outpatient ____ Emergency/Prompt Care ____ Other : ______________________

THE MEDICAL RECORDS ARE DATED: from - ______________ to - ______________.

THE FOLLOWING INFORMATION MAY BE RELEASED: (initial each type of information to release)

____ Medical/Surgical ____ Laboratory/Pathology ____ Medical Imaging Reports ____ Medical Imaging Films

____ Drug & Alcohol Abuse ____ Mental Health/Psychiatric (excluding Psychotherapy Notes) ____ Other

MENTAL HEALTH RECORDS – In the event that information released constitutes privileged mental health patient communications, the confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the afore-mentioned statutes.

DRUG AND ALCOHOL ABUSE RECORDS – In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Record regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AIDS OR HIV RELATED INFORMATION: This information has been disclosed to you from records protected by State Law. Connecticut State Law prohibits you from making any further disclosure without the written consent of the patient or as otherwise permitted by said law.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY TREATMENT OR PAYMENT. FURTHERMORE, I UNDERSTAND THAT ONCE INFORMATION HAS BEEN DISCLOSED SUBJECT TO THIS AUTHORIZATION, THE INFORMATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER BE PROTECTED BY STATE OR FEDERAL LAW.

PATIENT SIGNATURE*	DATE	
*If THE PATIENT has NOT SIGNED this form, please indicate the relationship of the signator to the patient. __ Parent/Guardian __ Administrator/ Executor of Estate __ Power of Attorney/Conservator Other -specify: ____________		
SIGNATURE OF REQUESTOR	DATE	WITNESS
PRINT NAME OF REQUESTOR	PHONE NUMBER	

THIS AUTHORIZATION MAY BE REVOKED IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT INFORMATION HAS BEEN OBTAINED OR RELEASED. YOUR RIGHTS TO REVOCATION MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES. THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE OF SIGNATURE, OR UPON THE FOLLOWING EARLIER EVENT, CONDITION OR DATE: ______________________.