



RELEASE OF MEDICAL INFORMATION FREQUENTLY ASKED QUESTIONS

FINDING YOUR MEDICAL INFORMATION:

If you have graduated within the last 7 years from a high school in Connecticut, your immunization records are kept with your high school and that may be another place you can request this information should you need this earlier than 5 business days.

WHEN IS THE INFORMATION AVAILABLE?

There is a 5 day business turn around time from the day we receive the information. Every effort will be made to accommodate 'emergency' circumstances but there is no guarantee that a request will be honored. We do our mailing of information on Fridays.

HOW LONG DO WE KEEP MEDICAL RECORDS?

We maintain records for only 7 years as required by state law.

IS THERE A COST TO OBTAINING THE MEDICAL INFORMATION?

We do not charge for any records requested from present or past students. We charge \$0.45 per page for records that are requested as are result of a subpoena and/or requests from legal offices.

SENDING RECORDS:

Will you send records to other places? Yes. We do not fax records. We will send them. You can opt to pick them up as well from our office.

QUESTIONS ABOUT FILLING OUT OUR RELEASE FORM:

The more information we can have as to what semester you were part time, full time, withdrew or graduated, the more easily we can locate your medical record. Those records that are not current are kept in a different facility.

REQUESTING MORE THAN ONE MEDICAL RECORD:

If you are requesting that your records be sent to more than one place, we will send you the records to forward to the places that you would like to have them sent.



UNIVERSITY HEALTH SERVICE

Authorization to Obtain and/or Disclose Health Information

1. I hereby authorize Central Connecticut State University Health Service to disclose and/or obtain (circle) my individually identifiable health information as described here to the person/organization named below. I understand that this authorization is voluntary and that it *may include information relating to AIDS, HIV infection, behavioral health service/ psychiatric care, treatment for alcohol and/or drug abuse.*

<i>PATIENT'S NAME: Maiden name or Name while attending the University</i>	<i>DATE OF BIRTH</i>
<i>ADDRESS:</i>	
<i>CITY:</i>	<i>STATE:</i>
<i>PHONE NUMBER:</i>	
<i>Social Security Number</i>	<i>Student ID:</i>

2. Dates of Service _____
 Are you presently a student at the University? Yes / No. If no, when did you last attend Central? ___/ ___ (mth/yr)
 Date of Graduation: (if already graduated) ___/ ___(mth/yr)
 Please list what semesters you were FULL time or PART time while attending the University:
 Part time: (list the semester) _____ Full time (list the semester) _____

3. Information: **to be disclosed** (please check one or more of the following)
 History & physical examination
 Laboratory tests
 Entire record (Consideration will be given to releasing the entire record ONLY when subsections of the record will not serve the intended purpose of the disclosure.)
 Outpatient progress notes. Describe which here: _____
 Immunization Data:
 Did you receive a Measles Vaccination during an inoculation program in 1989 at the University? Y / N.
 Other (please specify): _____

4. Please **DO NOT** release the following information: _____

5. I am requesting that this information be **disclosed** for the purpose of (i.e. legal reasons, continued care, insurance, another medical opinion, worker's compensation, research, personal use, social security): (please list reason) _____

6. Name and address of the person(s) /organization(s) **to whom the disclosure** is to be made.

<i>NAME</i>	
<i>ADDRESS</i>	
<i>CITY</i>	<i>STATE</i>
<i>ZIP</i>	

7. If disclosure is to be **mailed to you**, please indicate "**self**" in the space below or "**pickup**" if you wish to pick it up from our office.

Name and relationship to patient of individual authorized to pick up record(s) being released from the facility:

name

relationship

8. I understand this authorization may be revoked **in writing to the Director of Medical Records** at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire 6 months from the date of signature unless otherwise specified in the space provided here. **DATE OF EXPIRATION:** _____.
9. I understand that I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what Connecticut State law authorizes.
10. Central Connecticut State University Health Service, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
11. I understand that Central Connecticut State University Health Service may not condition treatment on the provision of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through Central Connecticut State University Health Service. In such cases, specific authorization for the research-related treatment protocols / studies must be signed as a condition of participation. In cases where Central Connecticut State University Health Service is requested by a third part to create health information solely for the purpose of shar4ing that information with the party that requested it, I understand that I must sing this authorization.
12. **Notice to Recipients:** *As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY if there is written authorization from the patient or his/her legal representative; as required or authorized by state and / or federal law; or if urgently needed for the patient's continued care.*

If this disclosure contains information relating to HIV, behavioral health, alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2 and Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

15. **Notice to Individual Requesting the Disclosure:**
Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan, and the information disclosed is NOT protected by Title 42 CFR Part 2 and Ch. 368x, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

 Printed Name of Patient

 Signature of Patient or Legal Representative

 Date

 Printed name of Legal Representative*

 Relationship to patient

* A copy of the personal representative's legal authority to act on behalf of the patient is attached.

 Signature of Individual Picking up Record

 Relationship to patient

For Office Use Only

Sign & Date	
Check identification	
Date records needed by:	
Charges:	
Copy of Authorization was provided to patient	