UCONN HEALTH

(Patient Identification Label)

Name:

Medical Record/DOB:

Request for Medical Records

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Email: _____

INFORMATION DISCLOSED TO

CHOOSE ONE: Disclose to ☐ Patient (Self) ☐ Other: _____

Name: _____ Phone Number: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Fax Number: (_____) _____

INFORMATION TO BE RELEASED

Date(s) of Service: From: _____ To: _____

☐ Abstract of Medical Record	☐ Billing/Payment	☐ Progress Notes	☐ Laboratory Results
☐ Complete Record	☐ Operative/Procedure Report	☐ Dental Notes	☐ Pathology Results
☐ History and Physical Exam	☐ Radiology	☐ Dental Xrays	☐ Immunizations
☐ Emergency Room Records	☐ Radiation Oncology	☐ Clinic/Office Note	☐ PT/OT/Speech Note
☐ Consultation Report	☐ Radiology Film	☐ Medical Images	☐ Other: _____
☐ Echocardiogram/EKG	☐ Discharge Summary	☐ UConn Health Pharmacy Services, Inc.	

If records contain any of the following specially protected information, you must initial that you specifically authorize release of these records.

(INITIAL _____) Alcohol, Drug, or Substance Use Treatment

(INITIAL _____) Behavioral Health Treatment

(INITIAL _____) HIV/AIDS Testing and/or Treatment

(INITIAL _____) Genetic Testing

DELIVERY METHOD: ☐ Pick-up ☐ Mail ☐ Fax ☐ Secure Email ☐ MyChart

FORMAT: ☐ Paper ☐ Electronic ☐ Review**

***If you want to view or inspect your information, you must schedule an appointment to review ONLY the information specified. If you select this option, the Health Information Management Department will reach out to you to schedule an appointment.*

Completion of this Request for Records form does not guarantee approval of your request. UConn Health will review the record request and will respond either by providing the requested records in the form and format indicated or by providing an explanation of denial within thirty (30) days from receipt of this request. I acknowledge that completion of this Request for Records does not constitute a HIPAA authorization.

_____ _____

Signature of Patient or Authorized Individual Date

_____ _____

Printed Name of Patient or Authorized Individual Relationship to Patient/Authority

If signed by someone other than the patient, provide documentation establishing authority as the patient's legally authorized representative.

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Abstract of Record
Hospital: This is a partial set of records from the patient's encounter. This set consists of History & Physical, Discharge Summary, ED Record, Operative Report(s), Pathology Results, Lab Results, Radiology Results, Consultation Report(s).
Medical Practice Records: This is a partial set of records that consists of the Office Visit Notes and diagnostic test reports from the encounter.

Complete Record
The group of records maintained by or for UConn Health that may include patient clinical and billing records or information used in whole or in part to make care-related decisions. This may include, but is not limited to: Emergency Department Provider and Nursing notes, History & Physical, Consults, Progress Notes, Operative/Procedure Reports, Discharge Summary, Diagnostic testing reports, Medication Administration Records, Pre- and Post-Operative Care, Consents, and Discharge Instructions.

NOTICES

Minors
If a minor has the authority to consent to a particular health care service without parental or other consent, or if the parent or guardian has agreed to confidentiality between the provider and the minor, the minor has sole authority to exercise his or her rights under HIPAA. Under appropriate circumstances, minors may consent to their own HIV testing and treatment, treatment for alcohol and drug abuse, outpatient mental health treatment, or treatment of sexually transmitted diseases without parental consent. In cases where the minor provides his or her consent, parents and others will not be recognized as personal representatives and so will not have access to the minor patient's protected health information (PHI) related to the treatment.

Psychiatric Records and Communications
In the event that information released constitutes privileged psychiatrist-patient communications: "The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (Conn. Gen. Stat. § 52-146i)

Drug and Alcohol Use Records
In the event that information released constitutes confidential Substance Use Disorder records: 42 CFR part 2 prohibits unauthorized use or disclosure of these records. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (42 CFR 2.31).

HIV Related Information
In the event that information released constitutes confidential HIV-related information protected under Connecticut Law: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits 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 law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." (Conn. Gen. Stat. § 19a-585(a))

Reproductive Healthcare or Gender - Affirming Healthcare Services
State law prohibits the disclosure of any protected health information related to reproductive health care services or gender-affirming health care services for the purposes of any civil action or any proceeding preliminary thereto or in any probate, legislative or administrative proceeding, without the written consent of the person to whom it pertains, except in limited circumstances as outlined in the law. As the patient, or the patient's conservator, guardian, or other authorized legal representatives, you have the right to withhold such written consent. (Conn. Gen. Stat. § 52-146w and 52-146x)

MAIL	UConn Health Health Information Management Release of Information 263 Farmington Avenue, MC2260 Farmington, CT 06030	OTHER	**Phone:** (860) 679-2787 **Fax:** (860) 679-1273 **Email:** PatientROIRequests@uchc.edu *(For Patient Use Only)*