
# Medical Record Information for Patients, Families and Others

The Health Information Management Department is located on the fourth floor at 10 Columbus Boulevard in Hartford,CT.

It is the obligation of Connecticut Children's to protect the confidentiality of the patient's medical record. Any information contained in the medical record is confidential and protected by federal and state law.

Patients will be furnished with a copy of their record, upon receipt of a completed Authorization for Release of Protected Health Information form. Parents of minors (under 18 years of age) or legally appointed guardian may obtain a copy of a minor's record upon receipt of a written request or a completed Authorization for Release of Protected Health Information form.

All inquiries regarding requests for access or copies of the Authorization for Release of Protected Health Information form should be directed to the HIM Department, Attn: Release of Information via phone, Monday through Friday, 8 am - 5 pm at (860) 837-5780 or in person at the above address, Monday though Friday, 8:30 am - 4:30 pm, excluding hospital holidays.

*Please Note: Parents of patients 18 years old and over are not entitled to any information from the patient's record unless they have proof of legal guardianship, conservatorship of person or appropriate power of attorney. Staff are unable to discuss the status of a request for records.*

Connecticut Children's

## Medical Records Requests

### *How do I request a copy of my health information?*

You can request a copy of your health information by completing the Authorization for Release of Protected Health Information form, which is located on page three of this document. The form also may be obtained from your Connecticut Children's care provider or by visiting www.connecticutchildrens.org/patients-and-families/medical-record-information. After completing this form, please submit to the Health Information Management (HIM) department:

***By Mail:*** *Connecticut Children's*
*Connecticut Children's Specialty Group*
*Health Information Management Department*
*Attn: Release of Information*
*10 Columbus Blvd., 4th*
*Floor Hartford, CT 06106*

***In Person:*** *Monday – Friday, 8:30 am - 4:30 pm*
*10 Columbus Blvd., 4th Floor*
*Hartford, CT 06106*

***Via Fax:*** *(860) 837-5785*

If you (your child) are hospitalized, the form may be given to the nursing staff on your (your child's) inpatient unit. If you have any questions, please call the HIM Department Monday – Friday, 8 am - 5 pm at (860) 837-5780

### *Who is authorized to sign for release of my health information?*

The following people are authorized to sign for release of personal health information:

- The patient.
- Parent (if the patient is younger than age 18).
- Parent and minor if the patient is 13 to 17 years of age and receiving psychiatric, alcohol, or drug treatment services
- If your child is 18 years of age or older, it is REQUIRED by law that he or she sign an "Authorization for Use and/or Disclosure of Protected Health Information" form allowing release of the medical record, including to release the record to you. (Please note: Parents of patients 18 years old and over are not entitled to any information from the patient's record unless they have proof of legal guardianship, conservatorship of person or appropriate power of attorney. Staff are unable to discuss the status of a request for records.)
- Legal guardian or conservator of person (proof of guardianship or conservator of person document mustbe provided).
- Power of attorney if the patient is unable to sign (legal document must be provided).
- Representative of the estate for deceased patients (copy of the death certificate and a copy of the representative of estate documents must be provided).

### *How much does it cost to obtain a copy of my health information?*

There is no charge for releasing copies of health information directly to healthcare providers, patients, or parents/guardians.

### *When will I receive a copy of the medical record?*

Copies are processed within 30 days from the date the request is received. Recipients will be notified if the request cannot be processed within that timeframe.

Connecticut Children's

# Medical Records Request

**10 Columbus Blvd, Hartford, CT 06106 • (860) 837-5780** *phone* **• (860) 837-5785** *fax*

**WWW.CONNECTICUTCHILDRENS.ORG**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Connecticut Children's and/or Connecticut Children's Specialty Group, Inc. to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this Authorization, but the revocation will not apply to information that has already been released in response to this authorization. The written revocation letter needs to be sent to the Health Information Management (HIM) Department of Connecticut Children's. I understand that my/my child's treatment is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that once the PHI listed below is used or disclosed as set forth in this Authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

**Please note that each section of the form must be completed in its entirety. Failure to complete a section (including dates) may delay the processing of your request. Please print clearly. ** Photo Identification may be requested for signature verification purposes.****

Patient Name _____ Date of Birth _____

Previous Names (if applicable) _____ Phone ( ) _____

Parent/Guardian Completing Form (please print name) _____

Patient Address _____

City _____ State _____ Zip Code _____

| FOR CONNECTICUT CHILDREN'S TO ***DISCLOSE*** RECORDS (**OR**) | FOR CONNECTICUT CHILDREN'S TO ***OBTAIN*** RECORDS |
|---|---|
| I authorize Connecticut Children's to disclose health information to:<br>Name: _____<br>Facility: _____<br>Address: _____<br>City, State, Zip: _____<br>Telephone: _____<br>Fax: _____ | I authorize _____<br>to disclose health information to:<br>Dept./Physician: _____<br>Connecticut Children's<br>282 Washington Street<br>Hartford, CT 06106<br>Contact Person: _____<br>Telephone: _____<br>Fax: _____ |
| **Method of Disclosure**<br>☐ Mail ☐ Pick-Up ☐ MyChart (if available)<br>☐ Fax (Healthcare Facilities/Providers **ONLY**) | |

The dates of service and the types of information to be used or disclosed are as follows: **Date(s) of Service/Department Requested**: _____

☐ History & Physical ☐ Discharge Summary ☐ ED Record ☐ Procedure/Operative Reports ☐ Immunizations

☐ Laboratory Reports ☐ Radiology Reports ☐ Radiology Images ☐ PT/OT/ Speech Audiology Notes ☐ Progress Notes

☐ Billing records ☐ Pathology Reports ☐ Entire Record ☐ Other _____

The purpose of this disclosure or use is:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ School ☐ At the request of patient ☐ Other: _____

**If records are needed for an UPCOMING appointment, please specify date of appointment: _____**

***I understand that state law prohibits use and/or disclosure of the PHI listed below unless specifically authorized by me. I understand that such information will not be used or disclosed in response to the above request unless I indicate my authorization by initialing below.***

**Mental Health/Psychiatric:** *(initials)* _____

**HIV Tests & Related Information:** *(initials)* _____

**Alcohol and/or Substance Abuse** *(initials)* _____

**EXPIRATION DATE:** Unless I revoke this Authorization or provide a different expiration date below, this Authorization will expire twelve (12) months from the date of execution. Other Expiration Date (may not exceed 12 months): _____

**Signature:** _____ Date: _____

**Check One: ☐ Patient ☐ Parent ☐ Legal Guardian**

***Note**: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.*

*PC 18-367 New 4/2018: Revised 112018, 1/2019 , 6/2019*