**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient’s full name Date of birth

I authorize Life Long Care Of New London, PLLC to:

**Release information to:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the following purpose(s):**

 Current treatment  Personal records  Insurance  Worker’s Comp.  Attorney

 Provider transfer  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of information requested:**

 Abstract (includes any available documents below Other health information:

or check only those documents needed):  Physician Orders  Assessment

 Discharge Summary  Laboratory Report  Progress Notes  Nurses’ Note

 History & Physical  Cardiology Report  Radiology Films/CD  Itemized Bill

 Consultation  Radiology Report  Medication Records

 Operative Report  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emergency Dept. Documentation

**Dates of care to be released**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I UNDERSTAND THAT:**

* Life Long Care will treat me even if I decline to sign this authorization.
* Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
* Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.
* I can revoke this authorization at any time by submitting a request in writing to Life Long Care. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
* **The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:**

**Drug and/or alcohol treatment Initials: \_\_\_\_\_\_\_\_ Psychiatric Initials: \_\_\_\_\_\_\_\_\_\_**

**Sexually transmitted disease Initials: \_\_\_\_\_\_\_\_ Genetic testing Initials: \_\_\_\_\_\_\_\_\_\_**

**HIV (AIDS) testing/treatment: Initials: \_\_\_\_\_\_\_\_**

This authorization expires in six months from the date of signature, or on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign Here

Date Here

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signature of patient or legal representative/guardian Authority or relationship or representative Date

(Attach copy of documentation of authority)