COLLABORATIVE
NATURAL
HEALTH
PARTNERS
LLC

In office use only
Physician_____
Date_____

Authorization To Release/To Receive Confidential Health Information

I hereby authorize records to be released to & from

☐ TO Collaborative Natural Health Partners, LLC
315 East Center Street, Manchester, CT 06040

☐ FROM Phone (860)533-0179 Fax(866)603-4163

☐ TO Doctor/Medical Facility:_____
Address:_____

☐ FROM City:_____
Phone:_____Fax:_____

From the Health Records of:

Name:_____Date of birth:_____

Relationship to the patient:____Self____Parent/Guardian____Power of Attorney

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted disease, HIV and AIDS. Other laws may apply.

Dates including:_____

____Labs____Entire Record____Imaging____Chart Notes____Other:_____

For the purpose of:

____Collabortive Care____Transfer Of Care____Consultation____Other:_____

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to (please check to exclude).

____Substance abuse____Mental Health conditions____Sexually transmitted diseases____HIV, AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for the law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my healthcare information, my information may be re-disclosed by the party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call the medical records office at (860)533-0179 to inquire about revoking authorization.

I understand that if I request my medical records for personal use, to hand carry to another healthcare provider, or for parties not involved in my healthcare, there may be a charge. Non-emergency release of records may take up to 30 working days. Emergency requests will be given priority processing. Emergency status applies only to release of record directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

Patient/Guardian Signature:_____Date_____