WALNUT HILL
PAIN MANAGEMENT & WELLNESS

1 Grove Street – 2nd FL • New Britain, Connecticut 06053
(Phone) 860-506-5050 (FAX) 800-597-3430
www.CTPainRelief.com

MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

By signing this form below, I authorize Walnut Hill Paing & Wellness (WHPW) to use, receive, release or disclose the below indicated protected health information. The patient or their representative may revoke this authorization by notifying WHPW in writing. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient. This Records Request/Release Form shall expire exactly one year from the signature date indicated below.

Person or Organization from whom records are being requested or to whom records should be released:

_____

Purpose for use, release or disclosure of protected health information:

_____

Protected Health Information to be sent to ***WHPW, 1 Grove St., 2nd FL - New Britain, CT 06053***

- ❑ Copies of all medical records for the period of _____to _____
- ❑ Copies of the information described below for the period of _____ to _____
- ❑ Examination Reports
- ❑ Lab, X-Ray, ED, Etc. Reports
- ❑ Reports and records from other physicians
- ❑ Other: _____

I understand that the following protected health information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions of a sensitive nature.

I authorize this information to be transmitted by way of ground parcel, fax, certified mail, electronic or direct delivery to, or pick up from ***Walnut Hill Pain Management & Wellness.***

I am fully aware of my right under HIPAA regulations and have signed a copy of WHPW's Notice of Privacy Practices. I have discussed any concerns I have with the release, use or disclosure of my protected health information with WHPW's Privacy Compliance Officer and/or other appropriate office personnel.

I understand that WHPW assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release WHPW form all legal liability that may arise from the authorization.

Patient's Name:_____ Signature:_____ Date:_____

Patient's Date of Birth:_____ Social Security Number:_____

If Minor, Parent/Guardian Signature:_____ Date:_____