UCONN HEALTH

(Patient Identification)

Patient Request to Access Medical Records

Patient Name: _____ _____ _____
(Last) (First) (Middle Initial)

_____ **Date of Birth:** _____
(Previous Name(s))

Phone:_____(☐HOME ☐CELL ☐WORK) Email: _____

Date(s) of Service or Date Range: _____

Information Requested (Please check appropriate boxes below):

☐ Abstract of Medical Record (History & Physical, Discharge Summary, ED Record, Operative Report(s), Pathology Results, Lab Results, Radiology Results, Consultation Report(s))		
☐ Discharge Summary	☐ History & Physical/Admit Note	☐ Radiology Reports
☐ Laboratory Test Results	☐ Pathology Result(s)	☐ Consultation Report(s)
☐ Pulmonary Function Test Result(s)	☐ Echocardiogram/EKG	☐ Immunization Record
☐ Emergency Department Record	☐ Outpatient Clinic/Office Note(s)	☐ Dental Clinic Note(s)
☐ Rehabilitation Dept./PT/OT Notes	☐ Cardiac Testing Result/Stress Test	☐ Dental X-rays
☐ Operative/Procedure Report(s)	☐ Itemized Bill	☐ Radiation Oncology
☐ UConn Health Pharmacy Services Inc.	☐ Radiology Films (requests processed by Film Library)	
☐ Complete Record (includes all above if applicable, plus nursing notes, ancillary notes, all testing, and consents.)		
☐ Other (please specify): _____		

I authorize disclosure of the following (please check):

☐ **Alcohol, Drug, or Substance Abuse Treatment Records** ☐ **Behavioral Health Treatment Records** ☐ **Reproductive Health**
☐ **HIV Testing** ☐ **Genetic Testing**

Format Requested: ☐ Paper Copy ☐ Electronic Copy (please specify format) *: _____
Requested Delivery Method: ☐ Mail ☐ In-person pickup ☐ Electronic Delivery

Health information transmitted via unencrypted email is not secure. I understand and accept that there are risks associated with transmitting my health information using unencrypted electronic formats, including access by an unintended third party. If I request that UConn Health provide my health information in an unencrypted format, UConn Health is not responsible for unauthorized access of my health information while in transit. Further, UConn Health is not responsible for safeguarding my information once delivered.

☐ View/Inspection**

*** If you want to view or inspect your information, you must schedule an appointment to review ONLY the information specified.***
To schedule an appointment to review your Medical/Dental Records, please call: 860-679-3577
To schedule an appointment to review your Dental X-rays, please call: 860-679-2838

Information to Be Released to: ☐ Self ☐ Other

Name: _____

Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
Email address (if requesting email delivery): _____

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I understand that I will receive a copy of this Form and that my request will be processed within thirty (30) days.

I understand that if I checked the "Paper Copy" box above, I may be responsible for paying a reasonable cost-based fee for supplies, labor, postage and/or copying in accordance with HIPAA and that the requested information will be mailed to me via US postal mail at the address indicated above.

For Disclosures to Third Parties Only:

If this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit 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 such regulations.

Return completed form via mail, fax or email to:

For Medical/Dental Records:

Mailing Address:	UConn Health Health Information Management Release of Information MC2260 263 Farmington Ave Farmington, CT 06030
ROI Office Fax No.:	860-679-1273
Email:	PatientROIRequests@uchc.edu

For Dental X-rays:

Mailing Address:	UConn Health Dental Medical Records MC2105 263 Farmington Ave Farmington, CT 06030
Office Fax No.:	860-679-7817
Email:	omfrclinic@uchc.edu

_____ _____

Signature of Patient or Authorized Representative*** Date/Time

_____

Printed Name of Patient or Authorized Representative ***

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Health Care Representative ☐ Conservator of the Person

☐ Executor/Administrator of Estate

*** A copy of the authorized representative's legal authority to act on behalf of the patient must be attached.

Name and relationship to patient of individual authorized to pick up record(s) being released from the facility:

_____