Please fill out and send to your previous physician prior to your appointment.

Records Transfer Request

Evan Schiff, MD & Helena Grabo, MD

Authorization to Disclose Health Information

Subject to the statements printed on the back, I, the undersigned or legal representative, hereby authorize:

Previous Physician:_____

Address: _____

Phone#: _____ Fax#: _____

to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and HIV related information regarding:

Patient Name: _____ DOB: _____

Do NOT transfer the entire medical record. ***Please transfer only the following records*** to my new Primary Care Physician(s), to whom the information may be disclosed and used:

- Last Physical Note
- Last Office Note
- Vaccination Record
- Most Recent Labs and EKG
- Last Colonoscopy and EGD
- Most Recent Mammogram/PAP
- Last Pap Smear/Bone Density
- Any Important Consults Last 5 years
- CT/MRI Reports Last 5 Yrs

****IF MORE THAN 25 PAGES PLEASE DO NOT FAX. MAIL TO ADDRESS BELOW:**

Evan Schiff, M.D.
Helena Grabo, M.D.
36 East Main Street
Avon, CT 06001

Phone: (860) 677-5533
Fax: (860) 678-1305

This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notification in writing, but if I do, it will not have any effect on actions taken before the revocation was received.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulation.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors receiving drug abuse treatment or treatment for STDs may sign their own authorization.

Signature of Patient (*or guardian if patient is a minor*):

_____ Date: _____

If signed by a Legal Representative, indicate your relationship to the patient below:
[ ] Parent [ ] Guardian [ ] Conservator [ ] Executor of Estate [ ] Power of Attorney [ ] Other _____

NOTICE

HIV RELATED INFORMATION

In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits 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 said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION

In the event that information released constitutes psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.