valley orthopaedic specialists
orthopaedic surgery | sports medicine | onsite x-ray | physical therapy

Main Office:
2 Trap Falls Rd Ste 404
Shelton, CT 06484
Phone: (203) 734-7900
Fax: (203) 513-3269

Oxford Office:
144 Oxford Rd
Oxford, CT 06478
Phone: (203) 734-7900
Fax: (203) 463-8957

Fairfield Office:
1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
Fax: (203) 955-1203
www.vosct.com

Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____
Date of Birth _____ **SSN #** _____ **Preferred Phone #** _____
Address _____
City _____ **State** _____ **Zip Code** _____

I hereby authorize Valley Orthopaedic Specialists to use or disclose my protected health information as indicated below to:

Name _____
Daytime Phone # _____ **Fax #** _____
Address _____
City _____ **State** _____ **Zip Code** _____

Information to be released:

From & To Dates _____
☐ Medical Report (s) _____
☐ X-ray (s) _____
☐ Physical Therapy Report (s)_____
☐ Online Patient Portal _____
☐ Other _____

Purpose of Disclosure:

☐ Changing Physicians
☐ Continuing care
☐ At my (patient) request
☐ Workers Compensation
☐ Second Opinion
☐ Legal
☐ Insurance
☐ School
☐ Access to personal chart via online Portal
☐ Other _____

I understand that this health information may include HIV – related information and/ or information relating to diagnosis or treatment of psychiatric disabilites and/ or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to the following:

- Substance abuse (including alcohol/drug abuse)
- Mental Health
- Psychotherapy Notes
- HIV related information (including AIDS related testing)

The confidentiality of this record is required under chaper 899 of the Connecticut General Statutes,as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X_____ _____
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Valley Orthopaedic Specialists Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

2 Trap Falls Road, Suite 404
Shelton, CT 06484
PH: (203) 734-7900 FAX: (203) 513-3269

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____ _____ _____
Records received by Date Relationship to Patient Date

FOR OFFICE USE ONLY

DATE REQUEST FILLED _____ BY _____
FEE COLLECTED _____ ACCT # _____ IDENTIFICATION PRESENTED _____