VOS valley orthopaedic specialists

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

Oxford Office:
220 Main St Ste 1F
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

Patient Name: _____ **Date of Birth:** _____
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:
☐ **Self** ☐ **Other (If other, please indicate person/entity below):**

Person/Entity Name: _____
Daytime Phone #: _____ **Fax #:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Information to be released:
- ☐ Entire Chart
- ☐ X-rays
- ☐ Office Notes Only
- ☐ Physical Therapy
- ☐ Test Results
- ☐ Other: _____

*If you have specific dates or a date range that you're requesting, please list dates/range below:
_____

Purpose of Disclosure:
- ☐ Changing Physicians
- ☐ Second Opinion
- ☐ Continuing Care
- ☐ Legal
- ☐ Personal
- ☐ Insurance
- ☐ Workers Compensation
- ☐ School
- ☐ Other: _____

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.

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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. I also understand that this health information may include HIV – related information and/ or information relating to diagnosis or treatment of psychiatric disabilities 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 and/or HIV-related information (including AIDS-related testing. The confidentiality of this record is required under chapter 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.

_____ _____ OR _____ _____
Signature of Patient | Date | Signature of 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? ☐ YES ☐ NO