Hartford Orthopedic, Plastic & Hand Surgeons, Inc.

Duffield Ashmead, M.D.
Board Certified Plastic Surgeon
Fellowship Trained Hand Surgeon
Director, UCONN Hand Fellowship

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Board Certified Orthopedic Surgeon
Fellowship Trained Hand Surgeon
Assistant Clinical Professor — UCONN

Christopher Dillon, PA-C
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Orthopedic Surgeon
Fellowship Trained Hand Surgeon

Julie B. Forster, PA-C
Board Certified Physician Assistant

REQUEST FOR RELEASE OF MEDICAL INFORMATION AND/OR X-RAYS

As required by the Health Portability and Accountability Act of 1996 (HIPAA) and Connecticut State Law, a medical practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. By completing this form, you are giving permission for the release of the records listed below for the stated purpose. Please review and complete this form carefully.

I hereby authorize Hartford Orthopaedic, Plastic & Hand Surgeons, Inc. d/b/a **The Hand Center** to release health and medical/treatment information on the patient listed below, which may include information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV related information. **Please print clearly.**

Patient's Name: ____ **Date of Birth**: ____________________

Other Name (maiden, for example): ________________________________**Date of Request**: _____________

Street Address____

City/State: _____________________________ **Zip**: _________________ **Telephone:** ____________________

☐ Entire medical record **OR** ☐ Specific Dates of Service/Body Part: _________________________________

☐ X-Rays ($10.00 fee for non-worker's comp x-ray discs) ☐ Billing Summary ☐ Therapy notes

Reason for Release (must be provided): ____

Send to: Name: ____

ATTENTION: ____

Mailing Address: ____

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I understand that I may revoke this authorization at any time by notifying **The Hand Center** in writing. I further understand that I may be unable to revoke this authorization if **The Hand Center** has already acted upon this request.

This authorization will automatically expire one (1) year after the Date of Request (above). I also understand that if the Protected Health Information that is disclosed under this Authorization includes confidential alcohol or drug abuse related information or confidential HIV/AIDS related information, the recipient may not re-disclose that information under Connecticut State Law.

____ ____

Patient's / Guardian's Signature **Print Name and Relationship if Not Patient**

Address (if Not Patient): ____

Telephone (if Not Patient): ____