MEDICAL AND INSURANCE RECORDS RELEASE / AUTHORIZATION STATEMENT

Name of complainant: _____
Name of patient: _____
Relationship of complainant to Patient: _____
Health Insurer: _____

I, the complainant named above and legally authorized representative of the patient, do hereby grant permission to the health insurer and medical provider(s) named above, and their legal representatives, to release records pertaining to the patient, including but not limited to medical, billing, and insurance records, to the Office of the Attorney General of the State of Connecticut, and to otherwise discuss with such Office the patient's case as necessary to resolve any outstanding medical bill, claim for coverage and/or pre-certification of coverage for any medical service rendered for the benefit of the patient.

Please check any of the following statements that apply:

____ The medical information I am releasing pertains to the treatment of HIV and/or AIDS, which I authorize to be used for the above stated purpose.

____ The medical information I am releasing pertains to substance abuse, which I authorize to be used for the above stated purpose.

____ The information I am releasing pertains to the treatment of a mental health condition, which I authorize to be used for the above stated purpose.

_____ _____
Date Complainant

This statement / notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Any other uses and disclosures will be made only with your written permission. You may revoke this permission at any time, or request restrictions on uses or disclosures of your medical information. You have the right to receive confidential communications concerning your medical information including an accounting of any disclosures made, and you have the right to inspect, copy, and amend medical information received by us.

We are required by law to maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practices, and abide by these terms. We reserve the right to change these terms. These changes will be available on request. You have the right to complain to this office or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by filing this records release and authorization statement.

This notice and authorization is effective as of the date of signature stated above.