LORI CALABRESE, MD **INNOVATIVE PSYCHIATRY**

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Authorization to Release / Obtain Medical Records

Patient Name: _____ Date of Birth: _____

Address:
_____City:_____
_____State:_____Zip:_____ ☐ HOME ☐ CELL ☐ WORK

Preferred Phone: _____

I hereby authorize Lori Calabrese MD, LLC to:

☐ **Release** Protected Health Information from my medical records to: ☐ **Obtain** Protected Health Information from my medical records from:

Name: _____ Phone/Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

Dates of Service:

☐ All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults And neuroimaging reports. This does not include any records designated as psychotherapy notes. _____

☐ Medication records only ☐ Labs and imaging studies only ☐ The following specific info only: _____

Purpose of Disclosure:

☐ Coordination of Care
☐ Consult/Second opinion
☐ Transfer of Care
☐ School / College
☐ FMLA / Disability
☐ Legal (Please specify): _____
☐ Family Member Access to Treatment
☐ Insurance application (e.g., long-term care)
☐ Other: _____

1. I understand that this authorization will expire one year after I have signed this form, or as specified here:_____
2. I understand that I may revoke this authorization at any time by notifying Lori Calabrese MD, LLC or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.
   ☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

_____ _____
Signature of Patient Date

_____ _____
Print Name

_____ _____
Parent/Legal Guardian/Authorized Person Date

Please send to:

Lori Calabrese MD, LLC
1330 Sullivan Avenue
South Windsor, CT 06074
Fax: (860) 648-9756
Email: info@loricalabresemd.com

CONFIDENTIAL