Michelle van Duinen, APRN

Quiambaug Cove Professional Center

107 Wilcox Road- Suite 105
Stonington, Connecticut 06378

Tel 860-245-5811
Fax 860-245-4752

Authorization to Release / Obtain Medical Records

Patient Name: ______________________ Date of Birth: ______________________

Address:
______________________City:_____
______________________State:_________Zip:______________ ☐ HOME ☐ CELL ☐ WORK

Preferred Phone: ______________________

I hereby authorize Michelle van Duinen, APRN, PLLC 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

__ 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.

Dates of Service: ______________________

__ 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 Michelle van Duinen APRN, PLLC 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:

Michelle van Duinen, APRN, PLLC
107 Wilcox Rd, Suite 105
Stonington, CT 06378
Fax: (860) 245-4752
Email:info@michellevanduinenaprn.com

CONFIDENTIAL