Duffield Ashmead, M.D.
Board Certified Plastic Surgeon
Fellowship Trained Hand Surgeon
Assistant Clinical Professor — UCONN

Daniel J. Mastella, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Hand Surgeon
Assistant Clinical Professor — UCONN

H. Kirk Watson, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Hand Surgeon
Clinical Professor — UCONN

The Hand Center

195 Eastern Boulevard
Suite 200
Glastonbury, CT 06033
(860) 527-7161
Fax (860) 652-8410

Billing Department
(860) 781-6263
Fax (860) 652-8412

Toll Free 1-877-358-HAND (4263)
www.thehandcenteronline.com

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 all 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 ☐ Billing Summary ☐ Therapy notes

Reason for Release (must be provided): _____

Send to: Name: _____
ATTENTION: _____
Mailing Address: _____
_____

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): _____