50 Mitchell Drive
Attn: H.I.M DEPT.
New Haven, CT 06511
HIM@cornellscott.org
Tel: 203-503-3140 Fax: 203-503-3143
Last Update: 9/1/26

You may submit the completed request form by mail, email, or fax. For additional assistance, please contact the number provided above.

Patient Information: Please enter the patient's information in this section. Ensure that all details are provided clearly and legibly to avoid any delays in processing the request.

Recipient of Information: Only one box, either '***Release***' *or* '***Receive***', should be selected. Please provide information for the ***Name / Organization*** in which your records are to be released or received in this section. If the patient and the requester are the same person, please enter your name and address in this section.

Purpose of Request: Please specify the purpose(s) of your request by selecting the appropriate option. If none applies, select 'Other' and indicate the purpose of your request in the space provided."

Protected Health Information to be Disclosed: Please provide dates of service for your request. Indicate what records should be released or received. If you want us to release all your medical record information, select ***'All information maintained by CS-HHC'.***

Sensitive Information: Your medical records may contain sensitive information. We will not release any sensitive information without your consent. Initial next to each item if you authorize the release of sensitive health information related to the testing, diagnosis and treatment for ***HIV/AIDS, Substance Use Disorders and Mental/Behavioral Health***.

Signatures: Please print and sign your name on the line designated ***Patient / Authorized Representative***. Appropriate documentation must be provided to verify your authority to act as the personal representative.