

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize Stamford Health Medical Group to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of **mental illness, drug and/or alcohol abuse and confidential HIV/AIDS** related information regarding:

PLEASE PRINT CLEARLY AND COMPLETE THE FORM ON BOTH SIDES

Practice Name: Stamford Health Medical Group
1111 Summer St 4th Floor
Stamford, CT 06902

Contact: Tel: 203-276-7409
Fax: 203-276-4134

Please be advised that there will be a sixty-five cent (65¢) charge per page to produce the requested information.

<p>Patient Information:</p> <p>NAME: _____</p> <p>AKA / MAIDEN NAME: _____</p> <p>DATE OF BIRTH: ____ / ____ / ____</p> <p>ADDRESS: _____ _____</p> <p>PHONE#: _____</p> <p>Physician Name(s): _____ _____ _____</p>	<p>The purpose of this disclosure or use is for the following reason:</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> At the request of the patient or legal representative</p> <p>The information may be disclosed to and used by the following:</p> <p>NAME: _____</p> <p>ADDRESS: _____ _____</p> <p>PHONE #: _____</p> <p>FAX #: _____</p>
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The date(s) of service and the type(s) of information to be used or disclosed is as follows:

Date(s) of treatment: _____

Entire medical record Laboratory reports Operative reports Billing Office / Progress Notes

Radiology reports

Other (please specify) _____

This authorization will be valid for a period of one year from the date below. I understand that I may cancel this authorization at any time by notifying the Practice in writing, but if I do it will not have any effect on actions that the Practice took before it received the cancellation.

I understand that my treatment or continued treatment by Stamford Health Medical Group is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors may sign their own authorizations for records relating to drug/alcohol abuse treatment, sexually transmitted diseases or HIV/AIDS related diagnoses, and in certain circumstances, Mental Health treatment records.

I understand that Stamford Health Medical Group may receive compensation for copying and processing fees related to the use/disclosure of my health information under this authorization.

PROHIBITIONS ON REDISCLOSURE NOTICE

Psychiatric Records and Communications

In the event that the information released constitutes privileged psychiatrist-patient communications:

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol

In the event that the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV Related Information

In the event that information released constitutes confidential HIV related information under Connecticut Law:

This Information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature of Patient

Today's Date

Signature of Authorized Representative

Witness

If signed by the Authorized Representative, indicate your relationship to the patient below and provide a copy of the supporting documentation:

- Parent Guardian Conservator Executor of Estate Power of Attorney
 Other (Please Specify)