

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or authorized representative, hereby authorize THE STAMFORD HEALTH SYSTEM 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 BOTH PAGES OF THE FORM\*\*\***

PATIENT INFORMATION	
Name	
AKA/Maiden Name	Date of Birth
Address	
City, State, Zip	
Phone	
INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING	
Name	Phone
Address	
City, State, Zip	
THE PURPOSE OF THIS DISCLOSURE OR USE IS FOR THE FOLLOWING REASON(s):	
<input type="checkbox"/> Personal use <input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> Other _____	
FORMAT AND DELIVERY METHOD	
<input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Pick up <input type="checkbox"/> Mail <input type="checkbox"/> FAX _____ <small>(Physician/Medical Facilities Only)</small>	
<input type="checkbox"/> Secure Email _____ <small>(Patients Only)</small>	
<input type="checkbox"/> <b>Hospital Records</b>	<input type="checkbox"/> <b>Medical Group Records</b>
DATES OF SERVICE MUST BE SPECIFIED HERE	DATES OF SERVICE MUST BE SPECIFIED HERE
<input type="checkbox"/> Ambulatory Care/Clinic records <input type="checkbox"/> Cardiology reports <input type="checkbox"/> Cardiology images (may be mailed separately) <input type="checkbox"/> Consultations <input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Department records <input type="checkbox"/> History and Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> Laboratory results <input type="checkbox"/> Neurology reports <input type="checkbox"/> Operative reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> Pathology slides (separate request required) <input type="checkbox"/> Psychiatric records (may require physician approval) <input type="checkbox"/> Radiology reports <input type="checkbox"/> Radiology images (may be mailed separately) <input type="checkbox"/> Entire medical record <input type="checkbox"/> Other, specify _____	<p style="text-align: center;"><b>PHYSICIAN/PRACTICE NAME(S)</b></p> <p>_____</p> <p>_____</p> <input type="checkbox"/> Office/Progress Notes <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Operative reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Entire medical record <input type="checkbox"/> Other, 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 Medical Record Department in writing, but if I do it will not have any effect on actions that the hospital took before it received the cancellation.

I understand that my treatment or continued treatment by The Stamford Health System 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.

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

I understand that The Stamford Health System 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.

_____	_____	_____	_____
<b>Patient's Signature</b>	<b>Patient's Printed Name</b>	<b>Time</b>	<b>Date</b>
		am pm	
_____	_____	_____	_____
<b>Authorized Representative's Signature</b>	<b>Authorized Representative's Printed Name</b>	<b>Time</b>	<b>Date</b>
		am pm	
_____	_____	_____	_____
<b>Witness's Signature</b>	<b>Witness's Printed Name</b>	<b>Time</b>	<b>Date</b>
		am pm	

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

- Parent   
 Guardian   
 Conservator   
 Executor of Estate   
 Power of Attorney  
 Other, specify \_\_\_\_\_

**OFFICE USE ONLY**

Requester ID verified by \_\_\_\_\_ Date copies released \_\_\_\_\_  Mail  Fax  Secure Email  Pickup  
Employee's Printed Name

**A copy of this signed authorization form must be given to the patient or patient's representative.**

