STAMFORD HEALTH
Healing. Reimagined.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal 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 THE FORM ON BOTH SIDES

Patient Information:

NAME: _____

AKA / MAIDEN NAME: _____

DATE OF BIRTH: _____ / _____ / _____

ADDRESS: _____

_____

PHONE#: _____

The purpose of this disclosure or use is for the following reason:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

The information may be disclosed to and used by the following:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX #: _____

Format you would like to receive disclosed information:

☐ Paper ☐ CD (Compact Disc) ☐ Fax

Method of Delivery (For Paper or CD only):

☐ Mail to address listed above ☐ Pick up On-Site

The date(s) of service and the type(s) of information to be used or disclosed is as follows:

Date(s) of treatment: _____

☐ **Continuing of Care Document:** (Includes: Next of Kin, Primary Care Provider, Advance Directives, Problem List, Family History, Social History, Allergies/Adverse Reactions/Alerts, Medications, Immunizations, Procedures and Discharge Summary)

☐ Discharge Summary	☐ Discharge Instructions	☐ Emergency Room Record	☐ History and Physical Exam
☐ Immunization	☐ Same Day Surgery	☐ Ambulance Reports	☐ Ambulatory Care/Clinic Record
☐ Consultations	☐ Operative Reports	☐ Laboratory Results	☐ Cardiology Reports
☐ Neurology Reports	☐ Cytology Results	☐ Psychiatric Information	**(Requires Physician Approval)**
☐ Pathology	☐ Pathology Slides	(Will be mailed separately)	
☐ Radiology Reports	☐ Radiology Films	(Will be mailed separately)	

☐ 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 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.

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 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 statues.

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.

Email Address: _____

_____ _____
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) _____

OFFICE USE ONLY

Requestor ID verified by: _____ MRN: _____ Date copies mailed: _____
Employee Name

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

Created: 12/12
Rev: 6/16