STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

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
1 Omega Drive, Building 3, 2nd Floor
Stamford CT 06907

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.

Patient Information:	**The purpose of this disclosure or use is for the following reason:**
NAME: ______________________	☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ Consent for communicating Personal Health Information ☐ At the request of the patient or legal representative
AKA / MAIDEN NAME: ______________________	
DATE OF BIRTH: _____ / _____ / _____	**The information may be disclosed to and used by the following:**
ADDRESS: ______________________ ______________________	**NAME:** ______________________
PHONE#: ______________________	**ADDRESS:** ______________________ ______________________
Physician Name(s) requesting from: ______________________ ______________________ ______________________	**PHONE #:** ______________________ **FAX #:** ______________________

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.