

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize the below mentioned to disclose or obtain health information, including if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name: _____ **Birth date:** ____/____/____ **Phone:** _____

Social Security #: _____

<p>Information may be <input type="checkbox"/> Disclosed <u>to</u> Below Facility <input type="checkbox"/> Obtained <u>from</u> Below Facility</p> <p>Name/Facility: _____ Mailing Address: _____ City/State/Zip: _____ Phone #: (____) _____ Fax #: (____) _____ <input type="checkbox"/> Hand/Carry <input type="checkbox"/> Mail <input type="checkbox"/> Fax</p>	<p>Information may be <input type="checkbox"/> Disclosed <u>to</u> Below Facility <input type="checkbox"/> Obtained <u>from</u> Below Facility</p> <p style="text-align: center;">Stanislaw Chorzepa, D.O. 211 New Britain Road, Suite 103 Kensington, CT 06037 Tel. (860) 893-0300 Fax. (860) 893-0301 Email: administrator@drchorzepa.com</p>								
<p><u>The purpose of this disclosure or use is for the following reason:</u></p> <p><input type="checkbox"/> Transfer of Care <input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> At the request of the patient or legal representative <input type="checkbox"/> Other (please specify) _____</p> <p><u>Dates of service of information to be used or disclosed:</u> _____</p>	<p><u>Requested Information:</u></p> <p><input type="checkbox"/> Complete Record</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> History & Physical</td> <td><input type="checkbox"/> Laboratory Report</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary</td> <td><input type="checkbox"/> EKG Report</td> </tr> <tr> <td><input type="checkbox"/> Operative Reports</td> <td><input type="checkbox"/> X-Ray Report</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Billing Statement</td> </tr> </table> <p><input type="checkbox"/> Other: _____</p>	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> X-Ray Report	<input type="checkbox"/> Consultations	<input type="checkbox"/> Billing Statement
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I understand that my treatment or continued treatment by _____ 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 request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying _____ in writing, but if I do it will not have any effect on actions that the release took before it received the cancellation.

Copy Fees: I understand that _____ may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at \$0.65 cents per page.

Signature of Patient or Legal Representative Date Printed Name

If not patient, state the relationship to patient below (legal documentation required as applicable):
 Parent Guardian Conservator Executor of Estate Power of Attorney Other: _____

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, part 2. A general authorization for the release of medical information is not sufficient for this purpose.