STAMFORD HEALTH

Stamford Health HIM Department
One Hospital Plaza
PO Box 9317
Stamford, CT 06904-9317
Fax 203 276 7327
Phone 203 276 7455

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):

☐ Personal use ☐ Medical ☐ Legal ☐ Insurance ☐ Disability ☐ Other_____

FORMAT AND DELIVERY METHOD

☐ Paper ☐ CD ☐ Pick up ☐ Mail ☐ FAX _____
(Physician/Medical Facilities Only)

☐ Secure Email _____
(Patients Only)

☐ **Hospital Records**	☐ **Medical Group Records**
DATES OF SERVICE MUST BE SPECIFIED HERE	**DATES OF SERVICE MUST BE SPECIFIED HERE**
☐ **Ambulatory Care/Clinic records** ☐ **Cardiology reports** ☐ **Cardiology images (may be mailed separately)** ☐ **Consultations** ☐ **Discharge Instructions** ☐ **Discharge Summary** ☐ **Emergency Department records** ☐ **History and Physical** ☐ **Immunizations** ☐ **Laboratory results** ☐ **Neurology reports** ☐ **Operative reports** ☐ **Pathology reports** ☐ **Pathology slides (separate request required)** ☐ **Psychiatric records (may require physician approval)** ☐ **Radiology reports** ☐ **Radiology images (may be mailed separately)** ☐ **Entire medical record** **Other, specify**_____	**PHYSICIAN/PRACTICE NAME(S)** _____ _____ ☐ **Office/Progress Notes** ☐ **Laboratory reports** ☐ **Radiology reports** ☐ **Operative reports** ☐ **Immunizations** ☐ **Entire medical record** ☐ **Other, specify** _____

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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.

Patient's Signature	Patient's Printed Name	Time (am / pm)	Date

Authorized Representative's Signature	Authorized Representative's Printed Name	Time (am / pm)	Date

Witness's Signature	Witness's Printed Name	Time (am / pm)	Date

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 _____ (Employee's Printed Name) Date copies released _____ ☐ Mail ☐ Fax ☐ Secure Email ☐ Pickup

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