

Stamford Hospital
30 Shelburne Road
P.O. Box 9317
Stamford, CT 06902
MRO 1-888-252-4146 Option #1
Phone: 203-276-7453
Fax: 203-276-7327



AUTHORIZATION FOR RELEASE OF INFORMATION

TO FOLLOWUP ON REQUESTS CALL MRO AT 1-888-252-4146 OPTION #1

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

Patient Name: _____ **Date of Birth:** ____/____/____

<p>The information may be disclosed to and used by the following:</p> <p>NAME: _____</p> <p>ADDRESS: _____</p> <p>TELE#: _____</p> <p>The purpose of this disclosure or use is for the following reason:</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> At the request of the patient or legal representative</p> <p><input type="checkbox"/> Other (please specify) _____</p>	<p>The dates of service and the type(s) of information to be used or disclosed is as follows:</p> <p>Date(s) of Treatment: _____</p> <p><input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Other (please specify):</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> Operative Reports _____</p> <p><input type="checkbox"/> Consultations _____</p> <p><input type="checkbox"/> Same Day Surgery _____</p> <p><input type="checkbox"/> ED Record</p> <p><input type="checkbox"/> Ambulatory Care Record/Clinic</p> <p><input type="checkbox"/> Psychiatric Information</p> <p><input type="checkbox"/> Laboratory Results</p> <p><input type="checkbox"/> Pathology/Cytology Reports</p> <p><input type="checkbox"/> Cardiology Reports</p> <p><input type="checkbox"/> Neurology Reports</p> <p><input type="checkbox"/> Radiology Reports</p> <p><input type="checkbox"/> Billing (direct to Patient Accounts 203-276-7572)</p> <p><input type="checkbox"/> Radiology Films (direct to Radiology 203-276-7863)</p>
--	---

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.

Signature of Patient or Authorized Representative

Date

Email Address:

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 _____