

# Soundview Medical Associates, LLC

Please mail to Medical Records Department, Soundview Medical Associates,  
761 Main Ave., Norwalk, CT 06851. You can also fax this to (203) 845-9193.

## AUTHORIZATION TO RELEASE INFORMATION

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate (MM/DD/YY): \_\_\_\_\_

Phone #: \_\_\_\_\_

Medical Record: \_\_\_\_\_

I hereby authorize this practice to make use of and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below. I understand I will be charged \$0.65 per page payable before records are sent or picked up.

This information is to be disclosed to:

Send Records to: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Description of information to be disclosed: \_\_\_\_\_

Reason for requested use or disclosure: \_\_\_\_\_

Please CHOOSE ONE of the following and initial:

\_\_\_\_\_ I hereby authorize the release of my ENTIRE medical record INCLUDING HIV, AIDS, HIV-related, alcohol, drug and psychiatric related information contained in my medical record.

\_\_\_\_\_ I hereby authorize the release of my medical record EXCLUDING HIV, AIDS, HIV-related, alcohol, drug and psychiatric related information contained in my medical record.

TO BE READ AND SIGNED BY PATIENT: I understand the following:

- a. I may revoke this authorization at any time by providing written notice to the office.
- b. I may be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- c. I am signing this authorization of my own free will, without pressure from an outside source.
- d. The information disclosed in the authorization may be subject to redisclosure by the practice and no longer protected by the federal law.
- e. I acknowledge that I have had the opportunity to review this authorization and understand the intent and the use.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient Representative \_\_\_\_\_

For office use only: Event or date upon which authorization will Expire: \_\_\_\_\_