AUTHORIZATION TO RELEASE INFORMATION

Patient Last Name: ________________________ First Name: ______________________________________

Street Address: ____________________ City: ______________ State: _______ Zip: ______________

Social Security #: ________________________ Birthdate (MM/DD/YY): __________________________

Phone #: ________________________________

This information is to be disclosed to:

Send Records to: Soundview Medical Associates

Street Address: 761 Main Avenue, Suite 201

City Norwalk State CT Zip 06851

Description of information to be disclosed: ALL

Reason for requested use or disclosure: TRANSFER

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: ____________________

For former patients of Associated Internists of Darien (Dr. Schwartz), please mail to:
Associated Internists of Darien, 40 Heights Road, Suite 201, Darien, CT 06820.
Or fax to 203-662-8906

Revised: 2/2010