

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: _____

Use this form to have your records transferred to Soundview Medical Associates.
Please fax or mail this form to your former doctor.