NEW MILFORD MEDICAL GROUP

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Jessica Harpll, PA-C
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize New Milford Medical Group to disclose or obtain health information, *including if applicable,* information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name:_____ **Patient DOB:**_____ **Date:**_____

1) Information may be: ____**Disclosed to** **OR** ___ **Obtained from Other Facility**

Name/Facility: _____

Mailing Address:_____

Phone#: _____

__ Hand Carry ____CD ____ Mail ____ Fax to:_____

2) The purpose of this disclosure or use is for the following reason:

____ Medical ___ Legal ____ Consult ____Transfer of care ____ Patient/Self

3) The date(s) of service to be disclosed: _____

4) Requested Information: ___ Complete Record ___ History & Physical ___ EKG Report ___ Lab Report ___ Consultations ___ Hospital Records ___ Echo Report ___ Ultra Sound (vascular or body)
___ Billing Statement(s) Other: _____

This authorization **will** be valid for a period of **three years (3)** from the signature date below. Medical Records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying New Milford Medical Group in writing, but if I do, it **will** not have any effect on actions that the releases took before it received the cancellation. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

Copy Fees: I understand that New Milford Medical Group may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with the Connecticut Statue at $.065 cents per page.

Fax or mail requests to above location. Please allow 48-72 hours for your request to be completed.

_____ _____ _____

Signature of Patient or Legal Representative **Printed Name** **Relationship to Patient** **Date**