Center for Gastrointestinal Medicine of Fairfield & Westchester, PC

500 West Putnam Avenue – Suite 100
Greenwich, Connecticut 06830

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	**Date of Birth**	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with applicable law, I understand that:

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line below. In the event the health information described below includes any of these types of information, and I initial the line on the box below, I specifically authorize release of such information to the person(s) indicated below.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient may be prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Unless otherwise protected by law, information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

Name and address of health provider or entity to release this information: Center for Gastrointestinal Medicine of Fairfield & Westchester, P.C. 500 West Putnam Avenue – Suite 100, Greenwich, Connecticut, 06830

Jennifer Barro, M.D. __ Nelson Bonheim, M.D.__ Neda Khaghan, M.D.___ Neal Schamberg, M.D.__ Alan Selkin, M.D. Felice Zwas, M.D.___

Name and address of person(s) or category of person to whom this information will be sent:

Specific information to be released:

☐ Entire Medical Record from (insert date) _____ to (insert date) _____

☐Specific Portions of the Medical Record as follows: _____

_____

☐ Other: _____

Include: (*Indicate by Initialing)*	
_____ **Alcohol/Drug Treatment**	
_____ **Mental Health Information**	
_____ **HIV-Related Information**	

Reason for release of information:	**Date or event on which this authorization will expire:**
__ At request of individual __Other: __Changing Physician	
If not the patient, name of person signing form:	**Authority to sign on behalf of patient:**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ **Signature of patient or representative authorized by law.**	**Date:** _____