OB/GYN OF FAIRFIELD COUNTY, LLC

1735 Post Road, Fairfield, CT 06824
Tel: (203) 256-3990 Fax: (203) 256-3993

1220 Linden Avenue, Stratford, CT 06615
Tel: (203) 380-4666 Fax: (203) 380-4671

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____

Phone #:_____ Date of Birth:_____

I authorize OB/GYN OF FAIRFIELD COUNTY, LLC,

(_) **SEND** to: Name:_____

Address:_____

Phone/Fax #:_____

(_) **RECEIVE** from: Name:_____

_____

A copy of my medical records (including any information related to counseling, testing, diagnosis, and/or treatment of alcohol/drug abuse, mental health, and/or HIV/AIDS related illness).

Please circle records to be released: Pap Smears Colposcopies Biopsies Mammograms

Operative Notes Pre-Natals **OR** Entire Records

Please circle reason for request: Moving Change of Insurance Change of Doctor

Other_____

1) I understand that this authorization will expire one year after I have signed the form or other time as specified_____
2) I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that revocation will be effective on the date OBGYN is notified except to the extent action has already been taken.
3) I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by privacy regulations.
4) I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5) I understand that there may be a fee for a copy of my medical records.
6) I understand the information to be disclosed or obtained may include mental health in accordance with COS Chapter 899, substance abuse treatment information in accordance with 42 CFR 2.1.2.67 or HIV/AIDS-related information in accordance with COS 19a-585(a) except as indicated below:
____No Mental Health _____No substance Abuse/Treatment info ___ No HIV/AIDS

Signature of Patient:_____ Date:_____