WESTWOOD EAR, NOSE & THROAT, P.C.
60 WESTWOOD AVE, WATERBURY CT 06708
P. 203-574-5997 F. 203-574-5987

AUTHORIZATION TO RELEASE INFORMATION & RECORDS REQUEST

Patient Name

Patient Address

Medical Record # Date of Birth

"I hereby authorize the disclosure of my medical records (my protected health information) as indicated below"

ALL SECTIONS BELOW MUST BE COMPLETED FOR PROCESSING

Description of information to be disclosed (Describe what is to be disclosed – please specific)

☐ Allergy
☐ Audio (Hearing Tests/Aids)
☐ Exam Notes
☐ Labs/Pathologies
☐ Surgery (In office & facility)
☐ Radiology Reports
☐ Other ________________________________

The practice **MAY or MAY NOT (circle one)** disclose my protected health information release to HIV/AIDS, psychiatric care, or drug/ alcohol abuse.

Description of the reason or purpose of this disclosure:

☐ Continuity of care (records to PCP or another referring physician)
☐ Transfer of care
☐ Other ____

This disclosure is being made to:
☐ Westwood Ear, Nose & Throat and CT Sinus Center

☐ ____
Address ________________________________
____
City ____
State _________________ Zip ____________
Phone ________________________________
Fax ________________________________

This disclosure is being made from:
☐ Westwood Ear, Nose & Throat and CT Sinus Center

☐ ____
Address ________________________________
____
City ____
State _________________ Zip ____________
Phone ________________________________
Fax ________________________________

EXPIRATION DATE: From(date): ___/___/___ TO (date): ___/___/___	OR	EXPIRATION EVENT:

I understand that I may cancel this Authorization at any time, in writing. If the practice has already used this Authorization or is this Authorization was used so that I could obtain insurance coverage, I may be unable to cancel the Authorization. I understand that the practice will not condition treatment or payment base upon my signing this Authorization. I am signing this Authorization freely. No one has forced me to sign this Authorization. I understand that the information disclosed could be re-disclosed by the recipient and is then no longer protected by federal regulations. I understand that if the information disclosed is related to HIV/AIDS and/or alcohol/substance abuse that the recipient may not disclose it under Connecticut State Law. I have reviewed this authorization. I understand it. A copy has been provided to me.

Date: ____/____/____ Patient (or Guardian) SIGNATURE: