Authorization For Use or Disclosure of Protected Health Information

To:____

____

I, the ___Patient ___Guardian ___Conservator/ Designee, hereby authorize this medical practice to use and disclose health information concerning

______________________ ______________ ____________________

Patient Name **Date of Birth** **Social Security Number**

This health information may be disclosed to and used by:

Ivette E. Diaz, M.D., LLC
304 Federal Road Suite 201 Brookfield, CT 06804
(203) 740-2593 Fax: (203) 740-8250

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS information.

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

The information may be used and disclosed only for the following purposes: (please specify)

____

Exclusions (please initial): Drug/Alcohol_____ Mental Health/Psychiatric_____

Sexual Transmitted Disease____ HIV/AIDS____

This authorization is valid for one year or until ___________, whichever comes first.

Patient Signature: ____________________________________ **Date**: ____________

Signature of Parent, Guardian, Conservator/Designee (if applicable):

_____________________________ **Relationship**: _________ **Date**: __________

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.

The confidentiality of this record is required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Connecticut Law, this practice may not use or disclose your individual identifiable health information without your authorization except as provided in our Notice of Privacy Practices..

A photocopy of this release is as valid as the original

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