Dr. Gayethri Narayanswamy
2701 Tamarack Avenue
South Windsor, CT 06074
Tel: 860-375-5141 Fax: 860-896-8190

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____
Address:_____
City, state, zip: _____ Phone:_____

I authorize: (enter your current physician's information)
Name: _____
Street Address, City, State, Zip:_____
Telephone: _____Fax:_____

To release copies of my medical records to: (enter your new physician's information)
Name:_____
Street Address, City, State, Zip:_____
Telephone:_____Fax:_____

The medical records are dated: _____ to _____

I authorize release of information of the following portions of my medical record:

_____Mental Health
_____Drug/Alcohol Abuse
_____Laboratory/Pathology
_____HIV/AIDS
_____Medical Imaging
_____Other: _____

My authorization is given freely and with the understanding that:

- I may refuse to sign this authorization; the health center may not condition my treatment on my provision of this authorization. However, the health center may charge a fee for copying and first class postage related to the use/disclosure of my health information under this authorization.
- I may revoke this authorization at any time by written request to the health center except where information has already been released in reliance on my authorization.
- This authorization is valid for one year from today's date, OR on the following date (at least 30 days after I signed)_____
- The information may be subject to redisclosure by the recipient and may no longer be protected by the health center's privacy practice or applicable privacy law.

Signature of patient (or legal representative):_____
Date: _____
Relationship to patient: SELF MOTHER FATHER LEGAL GUARDIAN OTHER:_____