Children's Medical Group of Greenwich

42 Sherwood Place

Greenwich, CT 06830

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient:_____
DOB:_____

Name of Patient:_____
DOB:_____

Name of Patient:_____
DOB:_____

I authorize The Children's Medical Group to release protected health information with respect
to my treatment, including information relating to the diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV/Aids related information, to:
Name:_____

Address:_____

_____
The charge for copied charts is 65 cents per page. We will contact you when your copies are ready to arrange for pick up and payment.

THIS IS A TRANSFER YES_____ NO_____ TO_____

REASON FOR TRANSFER:_____

I understand that The Children's Medical Group will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure unless my treatment is related to research.

This authorization is subject to revocation at any time by sending written notification of such revocation to the Office Manager of The Children's Medical Group and that such revocation is not effective to the extent that The Children's Medical Group has taken any action in accordance with and in reliance upon this authorization. I further understand that information released pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or state law.

This authorization shall expire 180 days after the date appearing below.
Date:_____

_____
Signature of Patient/Person Granting Authorization on Behalf of Patient