LAW OFFICES OF
TAD J. BISTOR, LLC

POST OFFICE BOX 1454
HARTFORD, CONNECTICUT 06144-1454
TELEPHONE (860) 570-1435
FACSIMILE (860) 570-1292
EMAIL TAD@BISTORLAW.COM
ALT. EMAIL BISTORLAW@GMAIL.COM

ALSO ADMITTED IN NEW YORK

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:______________________________________ **Date of Birth:**______________________

Social Security Number:_________________________________

I hereby authorize the use or disclosure of my individually identifiable health information by:

____ (name of facility)

as described below. I understand that this authorization is voluntary. I understand that information is being released pursuant to this authorization at my request and that the information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.

Upon presentation of this authorization, **or a photocopy thereof**, you may copy such records for a representative and you may release such medical or diagnostic materials as the representative requests.

Persons/organizations receiving the information:

Law Offices of Tad J. Bistor, LLC and/or its representatives.

Please use or disclose the following health information:

☐ The entire medical record (which may include all records, reports and medical materials, including pathology slides, in your possession, custody or control concerning the patient. "Records" for purposes of this authorization shall include, but not be limited to, correspondence, office notes, doctors' records, laboratory results, original X-rays, scans, or other diagnostic materials, medical reports, tissue blocks, and tissue slides.)

☐ The following limited health information:

____

____

Please initial next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for:

________ HIV / AIDS

________ Drug and/or Alcohol Abuse

________ Mental Health / Psychiatric Disorders

Purpose of use or disclosure of patient information:

The patient or the patient's representative must read and sign below:

1) Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: _____/_____/______ (DD/MM/YEAR).

2) I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions the provider takes before it receives the revocation.

____ ____________________________

Signature of patient or patient's representative Date

____ ____

Printed name of patient or patient's representative If patient's representative, relationship to patient