Eileen C. Comia, M.D.

35 Jolley Drive Suite no.102 Bloomfield, CT 06002
Tel (860)242-2200 Fax (860)242-2212

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____ (Please Print Name) hereby authorize

Name of Physician: _____

Address: _____

_____

_____

To Release My Medical Records Including All Confidential and Communicable Disease-Related Information To:

Eileen C. Comia, M.D.
35 Jolley Drive Suite no.102
Bloomfield, CT 06002

PLEASE MAIL THE RECORDS. DO NOT FAX TO OUR OFFICE. THANK YOU.

This authorization is for release of records of my care and treatment for the last ____ years inclusive.

I authorize release of all my records, including: Initials

HIV-Related Information	( ) Yes	( ) No	_____
Drug and Alcohol Treatment	( ) Yes	( ) No	_____
Mental Health Information	( ) Yes	( ) No	_____

Reason for disclosure:

_____

_____

This authorization is **valid for 6 months** unless revoked in writing. It cannot be revoked retroactively for information already released.

Patient's Date of Birth: _____ / _____ / _____ Social Security: _____

_____ _____
(Signature of Patient or Legal Representative) Date Signed

_____
(Relationship to Patient)