CRESCENT STREET OB/GYN, LLC.
49 Crescent Street Middletown, CT 06457
Phone 860-344-9993 Fax 860-344-0346

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:___________________________ DOB: __________________ Phone#: _____________________

PLEASE OBTAIN INFORMATION FROM:	**PLEASE SEND INFORMATION TO:**
____	____
Name of Provider/Clinic/Organization	**Name of Provider/Clinic/Organization**
____	____
Street Address	**Street Address**
____	____
City, State, Zip Code	**City, State, Zip Code**
Phone:_______________ Fax: _____________	**Phone: ________________ Fax: _____________**

REASON for disclosure of health information: (Please select one)

☐ **Personal Use** ☐ **Dissatisfied** ☐ **Insurance Change** ☐ **2nd Opinion** ☐ **Moving**
☐ **Legal** ☐ **Continuing Care** ☐ **Changing Physician** ☐ **Other: ___________________**

I AUTHORIZE the following information to be disclosed: (Please select all that apply)

☐ **Billing Records** ☐ **STD Record** ☐ **All Records** ☐ **Lab Test** ☐ **Lab test**
☐ **Mental Health** ☐ **HIV Record** ☐ **Alcohol/Substance** ☐ **Between Dates: _______ and _______**
☐ **Other: ____**

EXPIRATION of this Authorization: (Please select one)

☐ **90 Days after signature date** ☐ **On this date: ________** ☐ **Other: __________________________**

- **I understand that I may revoke this Authorization at any time by providing written notice to Crescent St Ob/Gyn, LLC. I understand that I may not be able to revoke this Authorization if Crescent St Ob/Gyn, LLC has taken action in reliance on the Authorization or if the authorization was obtained as a condition of obtaining insurance coverage.**
- **I understand that Crescent St Ob/Gyn, LLC will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.**
- **I understand that the protected health information disclosed under this Authorization may be subjected to redisclosure by the recipient and no longer protected by the federal Privacy Regulations.**
- **I also understand that if the PHI that is disclosed under this Authorization is confidential HIV/AIDS related information under Connecticut State Law.**
- **I acknowledge that I have carefully reviewed this Authorization and understand its provisions. A copy of this executed agreement will be given to me.**

*_____________________________________ *____________________ *____________________
(Signature of Person giving Authorization) Relationship Date