Naugatuck Valley
Gastroenterology
Consultants, LLC

Robert I. Leventhal, MD
Thomas A. Rockoff, MD
Anthony N. Schore, MD
Sara Miceli PA-C

Eileen S. Paradis, MBA
Administrator

166 Waterbury Rd
Suite 104
Prospect, CT 06712

203.756.6422 office
203.756.2448 facsimile

www.planetgi.com

HIPPA Compliant Records Release Form

Patient Information:
First Name:___________________________________ Last Name:_______________________________
Street Address:__________________________________ City____________________
State: ____________________ Zip:______________ Phone Number:______________________
Birthdate(mm/dd/yyyy): ____________________________

I,___________________________________, authorize (entity or practice name) to release the following medical information to: _________________________________ for the following purpose(s):____(or at the request of the individual).

Please initial the appropriate box:
____All of my medical records (as of the date of this release)
____All of my medical record except the following:________________________________
____Only the following information:____

This authorization also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):
____Any record of treatment for alcohol and/or other substance abuse
____Any record of mental health treatment
____Any record of testing, treatment, reporting, or research pertaining to infection with HIV, any sexually transmitted diseases, or pregnancy termination

This release is effective for 1 year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above-named party. I acknowledge receiving a completed copy of release.

A copy of this form is acceptable authorization for the release of the above information

Notices of Person Authorization Disclosure

The information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

Printed Name:____

Signature:____

Patient/Legal Representation/Officer of the Court Authorizing Disclosure
Date:____

Relationship to Patient:______________________________________