SightMD® Connecticut
(860) 649-9973

Records Release Authorization

Patient Name: _____ **Date of Birth**____/____/____

I authorize SightMD to disclose the following health information (choose ONE):

- All of my health information

- My health information relating to the following treatment or condition:

_____

- My health information covering the period from _____ (date) to _____ (date)

- Other: _____

The above party may disclose this health information to the following recipient(s):

- Myself

  Mailing Address: _____

  _____ Fax #: _____

- Other

  Name or Title of Organization: _____

  Address: _____ City: _____ State: ____ Zip: _____

  Phone #: _____ Fax #: _____

Send by (choose ONE): MAIL FAX

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. I understand this authorization is voluntary, my treatment will not be impacted, no matter if I sign this authorization or not. A copy of this authorization may be utilized with the same effectiveness as an original. I understand I am entitled to receive a copy of this authorization.

_____

Signature of Patient/Guardian/Power of Attorney Date