Eileen C. Comia, M.D.
Advance Biomedical Treatment Center

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

AUTHORIZATION TO OBTAIN and/or RELEASE MEDICAL RECORDS

I, (Patient Name) _____, hereby authorize Eileen C. Comia, M.D. LLC and/or Advance Biomedical Treatment Center, LLC to: (**Pick One**)

☐ **OBTAIN** information from: ☐ **DISCLOSE** information to:

Name:	
Address:	
Tel:	Fax:

I authorize the following Protection Health Information (PHI) to be obtained/disclosed from my medical records.

Date(s) of Service or Date Range: _____

- ☐ Complete Record
- ☐ Specific reports only:
  - ☐ History & Physical / Admit Note
  - ☐ Discharge Summary
  - ☐ Operative / Procedure Reports
  - ☐ Emergency Dept Reports
  - ☐ Laboratory Reports
  - ☐ Consultation Reports
  - ☐ EKG Reports
  - ☐ Radiology Reports
  - ☐ Immunization Record
  - ☐ Billing Statements
  - ☐ Other (please specify):
    _____
    _____
    _____

I specifically authorize the release of the following information. (**Initial all that apply**.)

_____ HIV/AIDS-related Information
_____ Drug and Alcohol Abuse Records
_____ Mental Health Information
_____ Sexually Transmitted Disease records

The purpose for requesting information:

- ☐ Medical
- ☐ Legal
- ☐ Disability
- ☐ Insurance
- ☐ Personal
- ☐ Other (please specify):
  _____

By signing this Authorization Form, I understand that:

- This authorization is voluntary and that my records may include protected health information related to AIDS, HIV testing and results, substance abuse treatment, and behavior health treatment.
- If this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and CT General Statutes (Ch.368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

- I understand that my treatment or continued treatment by Eileen C. Comia, M.D. LLC and/or Advance Biomedical Treatment Center is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulations.
- I understand that I may inspect or copy the information to be used or disclosed and that I may receive a copy of this signed authorization.

Expiration Date: This authorization will be VALID FOR ONE YEAR from the signature date below. It may be revoked at any time, in writing, by the patient or the legal representative. It cannot be revoked retroactively for information already released.

Copy Fees: There is a fee of $0.65/page for obtaining copies of medical records. Handling and postage charges are extra. Payment in-advance is required before the release of medical records. Please call for updated rates.

Connecticut
Title 20 §20-7c(b)
Upon a written request of a patient, his attorney or authorized representative, or pursuant to a written authorization, a provider, except as provided in section 4-194, shall furnish to the person making such request a copy of the patient's health record, including but not limited to, bills, x-rays and copies of laboratory reports, contact lens specifications based on examinations and final contact lens fittings given within the preceding three months or such longer period of time as determined by the provider but no longer than six months, records of prescriptions and other technical information used in assessing the patient's health condition.

- No provider shall charge more than sixty-five cents per page, including any research fees, handling fees or related costs, and the cost of first-class postage, if applicable.
- A provider shall furnish a health record requested pursuant to this section within thirty days of the request.

_____ _____
PRINTED NAME OF PATIENT DATE OF BIRTH

_____ _____
SIGNATURE OF PATIENT or LEGAL REPRESENTATIVE DATE SIGNED

If not patient, state the relationship to patient below (legal documentation required as applicable):

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Executor of Estate
- ☐ Power of Attorney
- ☐ Other: _____

PLEASE DO NOT FAX if records are more than 15 PAGES. Please mail copy. THANK YOU.

Return completed authorization to:
Mailing Address: Advance Biomedical Treatment Center / Eileen C. Comia, M.D. LLC
35 Jolley Drive Suite 102
Bloomfield CT 06002
Office Fax Number: (860)242-2212
Email: info@advbiomedtx.com