

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/Facility: _____

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	_____
Sexual Assault & Domestic Violence Records	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)