Greenwich Ear, Nose & Throat
Head & Neck Surgery
49 Lake Avenue, Suite 103
Greenwich, CT 06830
Phone: (203) 869-2030
Fax: (203) 869-9262

Stamford Ear, Nose & Throat
Head & Neck Surgery
125 Strawberry Hill Avenue, Suite 103
Stamford, CT 06902
Phone: (203) 348-7797
Fax: (203) 964-3140

Stephen J. Salzer, M.D.
Steven Bramwit, M.D.
Michelle S. Marrinan, M.D.
Elise Cheng, M.D.
Audiology & Hearing Aids
Perry Lerner, Au.D., FAAA
Joshua Jablonski, Au.D.

RECORDS RELEASE AUTHORIZATION

Patient Name: Phone Number:

Patient Address:
Street, City, State, Zip

Social Security Number # Date of Birth:

" I hereby authorize Greenwich Ear, Nose & Throat-Head & Neck Surgery, P.C to make uses and disclosure of my protected health information (information pertaining to my medical records and/or finical records) as indicated below"

THIS INFORMATION IS TO BE DISCLOSED TO:
Name:_____
Attention of:_____
Street Address:_____
City/ State/Zip:_____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____

_____

FOR DATES OF TREATMENT FROM TO

REASON FOR REQUESTED USE OR DISCLOSURE:
- ❑ Transfer of health coverage
- ❑ Personal use
- ❑ Form Completion
- ❑ Referral
- ❑ Change in health care provider

Other:_____

Do not fill out this section unless you wish to change the expiration date of this authorization.

This authorization expires in 6 months from the date signed at the bottom right of this form or earlier if stated below.

_____
STATE EARLY EXPIRATION DATE

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a) I may revoke this authorization at any time by providing written notice to the practice.
b) I may not be able to revoke this authorization if the practice has already taken action utilizing authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c) The practice will not condition treatment or payment based on signing this authorization.
d) I am signing this authorization freely and under no pressure from any individual to do so.
e) The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law
f) I acknowledge that I have has an opportunity to review this authorization and understand the intent and use.
g) I may request and receive a copy of this completed and signed authorization form.
h) **By signing this request I give permission for release of records that may include information relating to alcohol abuse, drug abuse, HIV (Aids) status, psychiatric problems and other sensitive medical information.**

Medical Records Copying Fees: 65¢ per page plus cost of mailing which is being billed in compliance with CT General Assembly Statutes, Section 20-7c

Patient Signature Date

Signature of other Authorized Party Relationship Date

OFFICE USE ONLY:
Authorized by:_____