Authorization for Release of Protected Health Information
(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)

To: Angelo Paul Sevarino, Esq.
110 Day Hill Road
Windsor, CT 06095

RE:
SSN/HICN#:
Date of Birth:

I authorize the use or disclosure of my protected health information by your office, company or organization as specified below. I understand that signing this Authorization is voluntary and that my medical provider may not require me to sign this Authorization before my doctor, hospital or institution provides me with treatment. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to my medical provider. I understand that a description of my right to revoke my Authorization is set forth in my medical provider=s Notice of Privacy Practices. I understand that information is being released pursuant to this Authorization at my request and that the information may no longer be protected by law or regulation and may be re-disclosed by the recipient.

1. a. Please use or disclose the following health information if such information exists:
   - ☐ The entire medical record; or
   - G The following limited health information:

   b. Your medical institution/provider cannot use or disclose certain information unless you specifically authorize such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis or treatment for:
   ___HIV/AIDS
   ___Drug and alcohol abuse
   ___Mental health/psychiatric disorders

2. Please specify the time period for the information you described above to be disclosed:
   - ☐ All information maintained at any time by my medical provider or
   - G Information maintained by my medical provider from __/__/__to __/__/

3. Please specify who may receive the information requested by this authorization:

   Angelo Paul Sevarino, Esq., 110 Day Hill Road, Windsor, CT 06095-1794 (860-687-1322)

Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: ____/___/_____.

By signing below, I understand and acknowledge the following:

- ! I have read and understand this Authorization;
- ! I am authorizing my medical provider to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- ! If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact my medical provider=s Privacy Officer.
- ! A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____ _____

Name of Individual, Date

Signature of Patient/Client Date

If different then the Patient/Client or Personal Representative

If signed by the Patient=s/Client=s personal representative, describe the legal authority of the representative to act on behalf of the Patient/Client._____.

Legal authority of representative verified by: _____