

Asis Medical Associates
1435 Chapel Street
New Haven, CT 06511
203-562-6741

Authorization for Release/Access of Protected Health Information (PHI)

Patient Name _____

Patient Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ SSN _____ Phone _____

I authorize Asis Medical Associates to:

_____ RELEASE information to _____ OBTAIN information from

Provider Name _____

Provider Address _____

City _____ State _____ Zip Code _____

PHI ***cannot*** be released or accessed unless you specifically authorize such under 42- CFR Part 2 of the federal confidentiality regulations and Chapter 899 of the CT General Statutes.

Please initial next to each item below to specifically authorize the release or access of health information relating to the testing, diagnosis or treatment for:

HIV/AIDS status _____ yes _____ no Initials _____

Drug and alcohol use _____ yes _____ no Initials _____

Mental health disorders _____ yes _____ no Initials _____

Signature: _____ Date: _____

Witness: _____ Date: _____