**Authorization for release of information**

I, the undersigned patient or legal representative, hereby authorize you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print facility or physician name and complete address and phone number) to release records requested below immediately.

\_\_\_\_Pathology and Cytology reports and slides

\_\_\_\_Radiology reports

\_\_\_\_All/Complete medical records

Purpose of this disclosure is for use in medical treatment. I understand that the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may be no longer be protected by federal privacy regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient name - please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_(patient date of birth)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient/authorized representative signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)

Please send this material to:

***Robert C. Babkowski MD FCAP***

***Chair of Pathology & Laboratory Medical Director***

***Stamford Hospital - Dept of Pathology & Laboratory Medicine***

***30 Shelburne Road***

***Stamford, CT 06897***