Thomas Cigno, M.D.

Thomas V. Cigno, M.D.
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Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

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   Ridgefield, CT 06877

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   _____ Complete health records* _____ Lab results/X-ray reports

   _____ Physical Exam _____ Consultation reports

   _____ Immunization record _____ Other (please specify): _____

* I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individuals or organization, by phone, fax, mail and in person with patient:

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of patient or legal representative Date