DR. THOMAS A. MARGIUS, P.C.
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MEDICAL RECORDS REQUEST/RELEASE AUTHORIZATION

I, the undersigned patient or legal representative, hereby authorize Dr. Thomas A. Margius or Thomas A. Margius, O.D., P.C. to disclose health information, including, if applicable, information relating to HIV/AIDS, behavioral/mental health, substance abuse (alcohol/drug), sexually transmitted diseases or genetic testing, regarding:

Patient First Name:_____Last Name:_____ Birth Date: ____/__ /____
Mailing Address:_____ City/State/Zip:_____
Phone: _____ Email Address:_____

Recipient of Information (check all that apply)		Purpose of Disclosure (check one)	
	Patient		At patient's request (no purpose required)
	Patient's authorized representative		Continuing care
	Provider (fill in box below)		Other (Specify):

Provider (if selected above)

Name/Facility	
Mailing Address	
City/State/Zip	
Phone Number	
Fax Number	
Email Address	

Choose How Information Is Sent (check box(es))	Patient	Auth Rep.	Provider
Email (encrypted; consent with signature required below)			
Fax			
Mail**			
Pick Up**			

**CT law allows a charge of up to $.65 per page copied.

By signing below, I acknowledge and understand that:

- **This authorization will be valid for a period of one year from the signature date below.** I understand that I may cancel this authorization at any time in writing by notifying Dr. Thomas A. Margius. Cancellation of the authorization will not apply to information that has already been released.
- Under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and, thus, may no longer be protected by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment, HIV/AIDS-related information and psychiatric/mental health information. I understand that I may inspect or request a copy of the information to be disclosed.
- **Email Consent**: I hereby consent to disclose my protected health information (PHI) via email at the email address(es) provided in this document. I understand that email communication is not completely secure and that there is a risk of unauthorized access to my PHI. I acknowledge I have the option to request alternative, more secure methods of communication if I choose. **Signature**_____
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law.

_____ _____
Signature of Patient or Legal Representative Printed Name

_____ _____
Legal Representative's Relationship (if applicable) Date

One form per patient. Return by email, mail or fax to the address below. May take up to 30 days to process.