Ciardiello & Bonadies
Surgery Group, PC
2200 Whitney Avenue, Suite 220 Hamden, CT 06518 ● Phone: 203.281.7000 ● Fax: 203.281.9300

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________________

Previous Name: ______________________________ Social Security #: ______________________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: **Ciardiello & Bonadies Surgery Group, PC**

Address: **2200 Whitney Avenue, Suite 220**

City: **Hamden** State: **CT** Zip Code: **06518**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________________

____

☐ All healthcare information

☐ Other: ____

Patient Signature: ______________________________ Date Signed: ______________________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.