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MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION (PLEASE PRINT):

Last Name: _____ First Name: _____ Date of Birth ____/____/____

Phone Number: (_____)_____-_____ *Notes:*_____

I hereby authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

___ Complete record (including but not limited to, progress notes; laboratory & diagnostics tests; radiological reports)

___ Records of care from dates: _____ to _____ ONLY

___ Pathology Slides (Date of slides if applicable: _____/_____/_____)

HOW WOULD YOU LIKE YOUR REQUEST PROCESSED:

___ I would like to PICK-UP a copy of my records

___ I would like to have my records FAXED to:
Name/ATTN: _____ Fax: (_____) _____-_____

___ I would like my records MAILED to: Name: _____

Street Address: _____

City, State, Zip Code: _____

PURPOSE OF DISCLOSURE:

l__l Personal Reasons l__l Changing Physicians l__l Consultation/Second Opinion l__l School

l__l Legal (please specify) _____ l__l Other (please specify) _____

* I am aware of and understand that Connecticut State Law allows a provider up to thirty {30} days to respond and/or provide my medical records.
* I understand that this authorization will expire thirty {30} days after I have signed this form.
* I understand that I may be charged a fee for copying my records as well as any applicable mailing fees.

Patient Signature: _____ Date: _____/_____/_____

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

DATE SLIDES PICKED UP (if applicable): _____ Fee Collected: $_____