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546 South Broad Street, Suite 1D
Meriden, CT 06450
Phone: 203-235-2511
Fax: 203-639-0809

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize the following Physician's Office:

_____

To release information to the following:

Name/Office: _____

Address: _____

Phone #: _____ Fax #: _____

For dates of Service: _____ or All dates of service: ☐

Reason for request: _____

This authorization is for use or disclosure of protected health information pertaining to: (Patient's Information)

Name: _____ Date of Birth: _____

Address: _____

Best phone number to reach you: _____

This authorization becomes effective immediately and shall remain valid for 30 months from the date received by the office, unless another date is provided: _____. Legally this office has 30 days from the date of receipt of this request to process.

I understand that I have a right to receive a copy of this authorization and a copy of the requested records. I understand that there may be a charge for my records.

_____ _____

Signed: Date: