DERMATOLOGY PHYSICIANS
OF CONNECTICUT

MEDICAL RECORDS RELEASE FORM

Patient Name: _____________________________ DOB: _________________

Address: ____

To: ____
(Physician's Name)

____
(Address)

_______________________________ _______________________________
(Phone Number) *(Fax Number)*

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

_____ Entire Medical Records _____ Pathology Reports Only

_____ Laboratory Results Only _____ Pathology Slides only

_____ Other: ____

From: __________________________ To: _____________________________

To: Dermatology Physicians of CT
Loyd Godwin, M.D.
_____ 4 Corporate Drive, Suite 386, Shelton, CT 06484
_____ 148 East Avenue, Ste 3B, Norwalk, CT 06851
Phone: 203-538-5682 Fax: 203-538-5685

This authorization will expire on ______________________.

I understand I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ _____________________
Signature of patient or legal representative Date

____
Relationship to patient (if signed by legal representative)