DERMATOLOGY PHYSICIANS OF CONNECTICUT

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ DOB: _____

Address: _____

To: _____
(Physician's Name)

_____
(Physician's 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: _____

Release to: **Dermatology Physicians of CT**

___ 4 Corporate Drive Suite 386, Shelton, CT 06484	T: 203 538 5682	F: 203 538 5685
___ 148 East Avenue Suite 3B, Norwalk, CT 06851	T: 203 538 5682	F: 203 538 5685
___ 6 Business Park Drive Suite 204, Branford, CT 06405	T: 203 208 4082	F: 203 208 4952
___ 1952 Whitney Ave 2nd FL, Hamden, CT 06518	T: 203 288 1142	F: 203 288 5086
___ 1 Bradley Road Suite 705, Woodbridge, CT 06525	T: 203 389 1185	F: 203 389 1427
___ 425 Post Road 2nd FL, Fairfield, CT 06824	T: 203 292 9490	F: 203 760 0172
___ 1 Long Wharf Drive Suite 103, New Haven, CT 06511	T: 203 787 4171	F: 203 865 3344
___ 6 Shaws Cove Suite 204, New London, CT 06320	T: 860 440 3744	F: 860 440 3718

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 re-disclosed by the recipient and the federal privacy laws or regulations may not protect the information.

_____ _____
Signature of patient or legal representative Date

_____
Relationship to patient (if signed by legal representative)