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 • P: 203-538-5682 • F: 203-538-5685

_____ 148 East Avenue, Suite 3B, Norwalk, CT 06851 • P: 203-538-5682 • F: 203-538-5685

_____ 6 Business Park Drive, Suite 204, Branford, CT 06405 • P: 203-208-4082 • F: 203-208-4952

_____ 2416 Whitney Avenue, Hamden, CT 06518 • P: 203-288-1142 • F: 203-288-5086

_____1 Bradley Road, Suite 705, Woodbridge, CT 06525 • P: 203-389-1185 • F: 203-389-1427

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)