Authorization of Release of Medical Records

Patient Information

Name:_______________

DOB:_______________

Date:_______________

I hereby authorize the office of ____________________ to release the following medical information:______________________ to ______________________________.

Patient/Guardian Signature:_________________________

Witness Initials:________

- **This consent does not pertain to the following sensitive information without my specific consent in the space below:**

Abortion   Sexual Assault   Drug/Alcohol Abuse   HIV Testing

Mental Health Visits   Venereal Disease   Infertility Studies

I hereby authorize the release of the sensitive information listed below:

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Patient/Guardian Signature:_________________________

Witness Initials:________

Enfield

Telephone:(860)741-2225   Fax:(860)741-2229

Simsbury

Fax:(860)651-1404