Authorization for Release of Medical Records

I, _____ hereby voluntarily authorize the disclosure of information from my health record.

Patient Information:

Name: _____ Date of Birth: ____ / ____ / _____

Address: _____

_____

Information Requested: _____

_____

_____

Purpose of Release: _____

_____

The Information is to be Provided to:

The Grove
158 Bridgeport Ave
Milford CT 06460

Fax: 203-301-4098

Phone 203-301-4097

Patients Signature: _____ Date: ____ / _____ / _____

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

Please make a copy of this release for your records

HIPAA Authorization for Release of Medical Records