OLD GREENWICH MEDICAL GROUP

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RECORDS RELEASE MEDICAL AUTHORIZATION

Patient Name: ________________________________ DOB: __________

Address: ____

City: _____________ State/Zip: __________ Telephone: ______________

Requesting records from (Dr. Name):_______________________________

Telephone:_______________________ Fax:_________________________

Which records are needed: Entire Chart □ Labs □ Office Visit Notes □

I hereby authorize and request you to release records to:

Name: ____

Address: ____

City: ______________________________ State/Zip:________________

Telephone: __________________ Fax: _____________________________

Reason for transfer/request: _______________________________________

Check how records are to be sent: Mail □ Pick-Up □ Fax □

Signature: __________________________________ Date:_______________

I UNDERSTAND THAT OLD GREENWICH MEDICAL GROUP DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTHCARE PROVIDERS.