

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 of Office: _____

Name of Doctor: _____

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.