Medical Records Release Authorization

New Canaan Internal Medicine

Patient Name:____

aka (maiden or other names used):____

Date of Birth:____

I hereby authorize and request Dr. ____________________________________ to release:

[ ] Entire medical record, including HIV, AIDS, HIV-related, alcohol, drug and mental illness information

[ ] Entire medical record, excluding HIV, AIDS, HIV-related, alcohol, drug and mental illness information

[ ] Entire medical record excluding ___________________________________

____

Medical records checked above should be sent to:

[ ] Patient, at this address: ____

____

[ ] Physician name: ____

At this address: ____

____

[ ] Other, name: ____

At this address: ____

____

Authorization:

Signed: ___________________________________ Date: _____________

Print Name: ____

I am the:

[ ] Patient
[ ] Guardian
[ ] Conservator
[ ] Patient Representative

ver. 10-31-06