OrthoConnecticut
World-class care, close to home.

761 Main Ave
Suite 115
Norwalk, CT 06854

36 Old Kings Hwy, So.
Darien, CT 06820

23 Riverside Ave.
Westport, CT 06880

p 203.845.2200
f 203.847.1940
myorthoct.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name (Print): _____

Date of Birth: _____

MRN (office use only): _____

Provider: _____

Patient Phone Number: _____

To Whom It May Concern:

We are pleased to provide you with these records. These records are released with the understanding that they are a permanent part of our records and the property of OrthoConnecticut.

If you would like your records sent to another doctor/practice, please provide the name of the doctor or practice and their fax number below.

Doctor or Practice: _____

Fax Number: _____

Patient Signature: _____

Date: _____

If you are requesting records for your own files, by signing below you are acknowledging that you have picked up your medical records.

Patient Signature: _____

Date: _____

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This letter will authorize you and/or an agent of OrthoConnecticut to obtain a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information.

At this time I am requesting the following:

□ Complete Record
□ Records of care from _____ to _____ only
□ Records of care concerning the following condition(s)/body part(s)
_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of drugs and alcohol abuse.

Please initial all exclusions:
____ Drugs/Alcohol ____ HIV/AIDS
____ Mental Health/Psychiatric ____ Sexually Transmitted Disease
____ Other: _____

Patient Name (Print): Date of Birth:

_____ _____

I understand that you will provide this information within 30 days from receipt of request.

Patient Signature: Date:

_____ _____
(Patient or person legally authorized to consent on patient's behalf)

Relationship to patient: _____