



761 Main Ave
Suite 115
Norwalk, CT 06854

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

36 Old Kings Hwy, So.
Darien, CT 06820

23 Riverside Ave.
Westport, CT 06880

p 203.845.2200
f 203.847.1940
myorthoct.com

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: _____