INTEGRATED DERMATOLOGY OF WATERBURY

Jeffrey Alter, MD • Rui Cheng, MD

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____
Address: _____

_____

Date of Birth: _____

RECEIVE Records

From: _____

_____

_____

Phone: _____ Fax: _____

I hereby consent and authorize you to release copies of my medical record, including current and previous medical records from other practices and hospitals, and/or clinics, which are part of my medical records. PLEASE NOTE: this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information: and any information relation to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

SEND Records

To: _____

_____

_____

Phone: _____ Fax: _____

___ SEND ALL OF MY MEDICAL RECORDS

___ SEND RECORDS FROM (DATE)_____TO (DATE) _____

___ SEND MY RECORDS PERTAINING TO _____

Patient's Signature: _____

Date: _____

Witness: _____

Waterbury Location
1078 W Main St, Waterbury, CT 06708
Phone: (203)-408-2730 • Fax: (203) 757-6300

Southbury Location
2 Pomperaug Office Park Ste. 208
Phone: (203)-757-1585 • Fax: (203) 757-6300