Medical Release Form

Eileen C. Comia, M.D.
Integrative Medicine Specialist
Board Certified in Int. Medicine

Advance Biomedical
Treatment Center
35 Jolley Drive Suite 102
Bloomfield, CT 06002
Tel. 860.2422200
www.advbiomedtx.com

Date: ____ /____ /_____

Name of Physician: ______________________________________

Address: ______________________________________

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Please send the medical records of:

Name: _________________________________
(Patient's Name)

Date of Birth: ___________________________

Address: _______________________________
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To: Eileen C. Comia, M.D.
35 Jolley Drive Suite 102
Bloomfield, CT 06002

PLEASE MAIL THE RECORDS. PLEASE DO NOT FAX.

Thank You.

Sincerely,

_______________________________________ ____________________
Patient Printed Name and Signature *Relation to Patient*