RELEASE OF MEDICAL RECORDS

NAME:_____ DOB:_____

ADDRESS:_____

I, the undersigned, hereby request and give permission to:

David A. Schwindt, MD
23 Clara Drive
Mystic, CT 06355
Phone: (860)572-0010
Fax: (860)536-2799

to send my medical records to:

_____

(Name of Person or Agency receiving information)

_____

(Address)

for the treatment period of:

_____

This information is needed for the following purpose:

_____

The specific information to be disclosed:

___All Records ___ER Records ___Physical Therapy ___EKG Reports

___Lab Reports ___X-Ray Reports ___Other Radiology Reports

___Operative Reports:_____

___History & Physical ___Discharge Summary

___Other:_____

If my initials appear here___, I specifically authorize release of drug/alcohol, &/or psychiatric records.
If my initials appear here___, I specifically authorize release of HIV/AIDS information.

This information disclosed is CONFIDENTIAL and is protected by state and federal laws which prohibit any further disclosure of this information unless further disclosure is permitted by written consent of the person whom it pertains to or as otherwise permitted by the regulations as stated.
I understand this consent can be revoked by me at any time upon written request (not retroactively), and this authorization will expire 90 days from the date shown below unless revoked earlier.

_____ _____ _____

Date Patient Signature Witness