Internal Medicine of Milford
40 Commerce Park, Suite 1
Milford, Ct 06460
P# 203-878-3531 F# 866-284-6188

Authorization to Release Medical Information

Patient Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Date of Birth ____/____/_____

I Authorize Internal Medicine of Milford to release medical information to:

Name of Entity: _____ Phone Number: _____

Street Address: _____

City _____ State_____ Zip _____

The above patient has requested that a copy of their medical record be sent to you. It is our experience that a new primary care physician may prefer not to receive a full (lengthy) print-out of the complete medical electronic/paper record. For the purpose of review/examination, please release:

_____ Complete Medical record (all physician notes/radiology/labs/specialists correspondence/ etc)
_____ Last five years – (complete medical records) ____ Last physical exam/ EKG/labs
_____ Last two years – (complete medical records) _____ Last two years of labs/radiology reports
_____ Specific information to be disclosed _____

All transferring patients records will be provided on a flash drive
**Flash drive – charge $15
** Flash drive to include registered mailing - $20
**Paper - charge $5 (less than 50 pages) or $20 plus postage (more than 50 pages) **

Reason for Request: |__| Change of PCP |__| Workers Compensation |__| Legal
|__| Insurance |__| Specialist |__| Other

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 for alcohol and drug abuse _____ (INITIAL).

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

Signed _____ Date _____
If Power of Attorney, please attach copy