Dermatology Associates
of Western Connecticut, PC

Medical Records Release

Patient Name: _____
Please Print

Patient Address: _____
_____
_____

Date of Birth: _____

I hereby authorize Dermatology Associates of Western Connecticut, P. C. to disclose my Personal Health Information (PHI) to:

Name of Individual or Entity: _____
Street Address: _____
_____
_____

My PHI disclosures may include:

Please initial here for entire record _____
Or list here specific information you would like disclosed:

_____
_____
_____
_____

The information is being requested for the following purpose (s): _____
_____
_____

Please be aware that there will be a fee of .65 cents per page, and you will be responsible for any postage.
Total pages _____

Patient Name: _____ Signature: _____
Please Print

Patient Representative Name: _____ Signature: _____
Please Print

Date: _____

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