Medical Records Release Form

Patient Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone Number:_____

I authorize the release of my medical records or other healthcare information, including intake forms, practitioner notes, reports, correspondence and any other written information concerning my health and treatment during the period of 1year prior to the date of signature below from the following:

_____
_____
_____
_____
_____

Medical records are to be released and send to the following:

MACY O&P, LLC
305 Flanders Road, Suite 2
East Lyme, CT 06333
Phone: 860-333-5558
Fax: 860-333-1342
Email: paul@macyop.com

_____ _____
Patient Signature Date

This authorization is valid until one year post the date of signature above.