Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385, 860-572-7711, www.fwcct.com

Empowering LIFE

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS

Patient Information:

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Authorization to release medical records to:

- ☐ Myself
- ☐ My spouse: _____
- ☐ Parent: _____
- ☐ Other: _____

These forms can be:

- ☐ Handed to me
- ☐ Faxed to: _____
- ☐ Emailed (must also complete the Email Consent Form)
- ☐ Mailed (postage required)

Signature:_____ Date:_____

Printed medical records are $.65 per page and may also require a minimum of $1.00 postage fee.