

# RECORDS RELEASE

To \_\_\_\_\_  
(Doctor/Hospital Requesting Records From)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

## HIGH RIDGE FAMILY PRACTICE

Alan Falkoff, M.D., David Berkun, M.D.,  
Melissa Montaruli A.P.R.N. Lindsay A Green A.P.R.N.,  
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**STAMFORD, CT 06905**

**Telephone: 203-322-7070**

**Fax: 203-322-2389**

Records requested: **ALL** \_\_\_\_\_

Other Reports:

**Consult\_\_ Discharge Summary\_\_ EKG\_\_ Immunization\_\_**

**Lab Report\_\_ Physical\_\_ Pathology\_\_ Progress Notes\_\_**

**Radiology\_\_**

Print Name of Patient

Date of Birth

**From:**

**To:**

Date of Records

Patient's Signature

Date