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,
Soohyun Nam A.P.R.N., Eileen Madsen A.P.R.N.,
Lynda G Royce A.P.R.N

30 BUXTON FARMS ROAD, SUITE 210
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

2020.1