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,
Alexandra Hagerman 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