



535 Saybrook Road Middletown, CT 06457 Tel: (860)347-9377 Fax: (860) 347-4146

# Medical Records Release Authorization

Connecticut Eye Physicians, P.C.  
Middletown, CT 06457  
Phone: (860) 347-9377 | Fax: (860) 347-4146

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## Patient Information

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone: \_\_\_\_\_

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## Authorization

I authorize the release of my medical records:

### From (Provider/Facility):

Name: \_\_\_\_\_  
Fax: \_\_\_\_\_

To:  
Connecticut Eye Physicians, P.C.  
Fax: (860) 347-4146

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## Records Requested

- Complete Record
  - Office Notes
  - Test Results / Imaging
  - Billing Records
  - Other: \_\_\_\_\_
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## Purpose

Medical Care  Insurance  Personal  Legal  Other: \_\_\_\_\_

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## Acknowledgment

I understand my records may include sensitive information (mental health, substance use, HIV, etc.). I may revoke this authorization in writing at any time. This authorization expires in one (1) year unless otherwise specified: \_\_\_\_\_

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## Signature

Patient/Representative: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Relationship (if applicable): \_\_\_\_\_

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## Submission

Fax: (860) 347-4146