

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I am Requesting Records of Doctor:

Name of facility or person: _____

Address: _____

Telephone number: _____ Fax number: _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish Dr. Cheryl Vincent information from my medical records. Please photocopy all pertinent written documents for blood tests results and Diagnostic reports for NO MORE than 1-2 years previous.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance of the authorization.

I hereby release Dr. Cheryl Vincent any and all of her employees, agents managing members, and any of the attending physician(s) that I am requesting records of and /or from any and all legal responsibility or liability for the release of the above information to the extent authorized. *A copy of the authorization shall be valid as the original.*

I understand that there may be a fee for this service depending on the number of pages photocopied. If such a fee is to be paid, it shall be paid by me, the requestor and not Dr. Cheryl Vincent. However; no such fee is usually charged if these records are requested for continuing medical care.

Patient's name _____

Patient's address _____

Telephone number _____

Date of birth _____ Social Security Number _____

Signature _____ Date _____

Please send a copy of all records to:

Simsbury Chiropractic and Wellness

Dr. Cheryl Vincent D.C DABCI

540 Hopmeadow Street

Simsbury, CT 06070

Phone 860-651-3355 – Fax 860-408-9648