

# Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385, 860-572-7711, www.fwcct.com

## Empowering LIFE

**Note to Requestor of Records:** There may be a \$.65 per page charge for copies of the medical records as well as any shipping costs incurred.

### AUTHORIZATION TO RELEASE MY MEDICAL RECORDS

**This Document Authorizes the Release of Medical Records from the Office Of:**

Dr. \_\_\_\_\_  
Office: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Please Forward These Medical Records To:**

Drs: \_\_\_\_\_ Frank Musante &/or Kendra Becker  
Office: \_\_\_\_\_ Family Wellness Centre of Connecticut  
Address: \_\_\_\_\_ 181 Cross Roads  
City: \_\_\_\_\_ Waterford State: \_\_\_\_\_ CT Zip Code: \_\_\_\_\_ 06385  
Phone: \_\_\_\_\_ 860-572-7711 Fax: \_\_\_\_\_ 860-574-9014

**Patient Information (Please Print):**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Please Release a Copy of Any of the Following Medical Records:**

- |  |  |
|--|--|
| <input type="checkbox"/> Progress / SOAP Notes | <input type="checkbox"/> X-Rays / Imaging Studies    |
| <input type="checkbox"/> Operative Notes       | <input type="checkbox"/> Diagnostic tests            |
| <input type="checkbox"/> Laboratory Results    | <input type="checkbox"/> Case Narrative (If Present) |
| <input type="checkbox"/> Other: _____          |  |

**I Hereby Authorize the Release of My Medical Records:**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_