

Associated Physicians of Southbury

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Patient Directed Release of Records Directly to Patient or to a Designated Person

Patient Name: _____ Date of Birth: _____

Patient Home Address: _____

Patient telephone number: _____

I hereby request a copy of my medical records, as contained in the designated record set of Associated Physicians of Southbury, be made available to me, or a copy provided, consistent with my wishes below. I understand there may be a charge for the copy, which can include the labor costs of preparing the copy, supplies, and postage.

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Section 1. Scope

Scope of records requested:

_____ My entire record.

_____ Only a portion of my records (describe): _____

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Section 2. For Records Going Directly to the Patient.

_____ I wish the copy sent to me at this address: _____

_____ I will pick up the copy in person.

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Section 3. For Records Going Directly to Someone Other Than The Patient.

Use this portion only if a patient wants a copy of the records sent directly to someone else.

I direct you to send a copy of my records, as set forth in Section 1 above, to another person, whose name and address I have listed below:

Name and address of person who will receive records:

Name: _____

Address: _____

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Section 4 . Patient Signature Required.

Signature of Patient/Client, or his/her representative, or Parent or guardian if a minor, please specify relationship to Patient /Client.

Date

If a representative signs, please describe the representative's authority to act on behalf of the patient:
