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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth:_____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

Facility or Physician _____

Address: _____

To:

Richard A. Bartlett, M.D., F.A.C.S.
77 Pond Avenue, 104C
Brookline, MA 02445
Phone: 617-735-1800 Fax: 617-735-1810

Please release a copy of all my medical records including but not limited to progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____