**Ground Force Medicine LLC**

Sara B. Frawley ND Sara B. Frawley ND

80 Shunpike Rd 850 N. Main St Ext

Suite 101 Bldg 2 Suite 3C

Cromwell, CT 06416 Wallingford, CT 06492

**Medical Records Release**

|  |  |  |  |
| --- | --- | --- | --- |
| (Name of Patient) |  |  | (Birthdate) |
| (Street Address) |  |  | (City, State, Zip Code) |
| **Authorizes:** |  |  | **Release of Records to:**  **Sara B. Frawley N.D.** |
| (Name of Physician) |  |  | Phone: 203-293-7293 |
| (Name of Health Care Facility) |  |  | Fax: 877-784-2390 |
| (Street Address) |  |  |  |
| (City, State, Zip Code) |  |  |  |
| **Information to be Released:**  All Clinic Records | Visual Fields |  | Lab Reports |
| Office Notes  Photographs | X-Ray Reports |  | Other (Specify) |

List other facilities’ records to be included when releasing for the purpose of continuing medical care:

**For the Following Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

|  |  |  |
| --- | --- | --- |
| Mental health | AIDS test results | Drug abuse |
| Developmental disabilities | AIDS-released disease diagnosis | Other |
| Alcoholism |  |  |

**Purpose or need for disclosure: (check applicable categories)**

|  |  |  |
| --- | --- | --- |
| Further medical care | Payment of insurance claim | Legal investigation |
| Application for insurance | Vocational rehabilitation evaluation | Personal |
| Disability determination | Other (Specify) |  |



**I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature of Patient/Parent: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if signed by person other than patient, state relationship and authorization to do so)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient is:** | Minor | Incompetent | Disabled | Deceased |
| **Legal authority:** | Legal | Legal guardian | Next of kin deceased |  |