

# Ground Force Medicine LLC

Sara B. Frawley  
4 Willowbrook Rd  
Cromwell, CT 06416

## Medical Records Release

\_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Birthdate)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip Code)

### Authorizes:

**Sara B. Frawley N.D.**

Phone: 203-293-7293

Fax: 877-784-2390

### Release of Records to:

\_\_\_\_\_  
(Name of Physician)

\_\_\_\_\_  
(Name of Health Care Facility)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip Code)

### Information to be Released:

All Clinic Records

Visual Fields

Lab Reports

Office Notes

X-Ray Reports

Other (Specify)

Photographs

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:

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

<b>Patient is:</b>	Minor	Incompetent	Disabled	Deceased
<b>Legal authority:</b>	Legal	Legal guardian	Next of kin deceased	