Medical Record Release Form

Radiology of Greater New Haven
1952 Whitney Avenue, 3rd Floor
Hamden, CT 06517
p. (203) 848-1708 | f. (203) 848-1777

Patient Information **Request Date:** _____

First Name | Last Name | Date of Birth | Social Security Number

Primary Phone ☐Home ☐Cell ☐Other | Secondary Phone ☐Home ☐Cell ☐Other | Email Address

I authorize the release of records, reports and/or films to the following facility and/or person:

Facility/Provider | Address | Phone | Fax

Facility/Provider | Address | Phone | Fax

Description of records, reports and/or films being released (Date of service, name of procedure, etc):

Signature of patient, legal guardian, personal representative | Printed Name | Date