

Greenwich Integrative Medicine, P.C.



A note to our patients:

Please send this form to your physician, hospital or clinic in time for the records to arrive in our office before your appointment. Thank you.

MEDICAL RELEASE FORM

Please fill in the name of the physician, hospital or clinic from which you are requesting information:

Please forward copies of my:

Laboratory work _____ Diagnostic studies _____ Operative reports _____

Pertinent report(s) related to the following medical problem(s):

PLEASE DO NOT SEND ORIGINAL X-RAYS.

Patient Name: _____

Date of Birth: _____ Phone: _____

Signature: _____ Date: _____

Please send medical records to the **Center for Integrative Medicine**.

35 River Road
Cos Cob, CT 06807-2717
(203) 863-3615
Fax (203) 863-4538