Greenwich Integrative Medicine, P.C.

Affiliated with GREENWICH HOSPITAL YALE NEW HAVEN HEALTH

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 provide 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 (Please print clearly.):____________________________________

Date of Birth: ________________________ Phone: ________________________

Signature: ___________________________ Date: _________________________

Please send medical records to Greenwich Integrative Medicine, P.C.

35 River Road
Cos Cob, CT 06807-2717
Phone 203-863-3615
Fax 203-863-4538
www.greenwichintegrativemedicine.org