Internal Medicine of Milford
40 Commerce Park, Suite One
Milford, CT 06460

# AUTHORITY TO SHARE MY MEDICAL INFORMATION

I _____, hereby give my permission to the
Please Print Legal Name
Physicians and/or their agents at Internal Medicine of Milford to release (verbally or written) my medical information, including but not limited to, answering of questions regarding my medical condition, lab and diagnostic results to:

Name (s) of person (s) to which permission is being granted,

1. _____ _____
Print Name Signature of person

Relationship to patient _____

2. _____ _____
Print Name Signature of person

Relationship to patient _____

3. _____ _____
Print name Signature of person

Relationship to patient _____

I understand that any information in my health record, relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health services, and or the treatment for alcohol or drug abuse, will only be released to me or a person that I have designated on the above form.

** This release shall be valid until I revoke this Authorization in writing **

_____ _____
Signature of Patient Date

_____
Date of Birth