

Connecticut Neck & Back Specialists, LLC

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Authorization and Consent to Disclose Medical Information

Patient Name: _____

Other Name: _____

Date of Birth: _____

The undersigned hereby authorizes **Connecticut Neck & Back Specialists, LLC** to disclose information from the medical record of the above-named patient to the following person/organization listed below:

(Name of Person or Organization) (Address) (Relationship)

Per **Connecticut Neck & Back Specialists, LLC** policy, patients of our practice are entitled to one copy of their medical records.

This information is to be released for the following purpose:

- Continuing Care Litigation Insurance Claim
 Other - Explain: _____

This consent to release medical information is limited to the following:

- All Related Records Radiology Films Radiology Reports Office Notes Operative Reports
 Other - Explain: _____

I understand that I may revoke this consent at any time. I do not authorize further release to any third party. I understand that once information is released pursuant to this authorization, the clinic, their employees and my physician cannot prevent the redisclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

Signature of Patient/Guardian Relationship to Patient if Signed by Guardian

Date of Patient's Signature Reason Patient Unable to Sign

Witness:
A photostatic copy of this authorization shall be considered as effective and valid as the original.