AUTHORIZATION TO OBTAIN MEDICAL INFORMATION
PLEASE PRINT CLEARLY

Patient's Name_____

Address_____ Town_____

State_____ Zip_____ Home Phone_____

Birthdate_____

I Authorize _____ to release medical information from my medical records to:

Kevin P. McGrath, M.D.
Adult and Pediatric Allergy and Asthma of CT
912 Silas Deane Hwy #100
Wethersfield, CT 06109
P: 860-257-3535
F: 860-257-0551

For the purpose of Review/Examination, I further authorize you to provide such copies thereof as may be requested, the foregoing is subject to such limitation as indicated below: (Initial on Applicable Line(s) Below)

_____ Entire Record

_____ Specific Information_____

_____ Old Records from Previous Physician_____

I give special permission to release any information regarding:

____ Substance Abuse ____ Psychiatric/Mental Health Information ____ HIV Information

Reason for Request_____
This Authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Patient/ Guardian Date

_____ _____
Witness Date