Arthur H. Skalski, M.D.

Internal Medicine F.A.C.S.G.
151 Hazard Ave. Suite # 10
Enfield CT 06082
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Request for Release of Medical Records

Patient Name: _____ **Date of Birth:** ____/____/____

Address:

_____

_____

I hereby authorize and request that my records be released **from**: (include name and phone number of doctor you are transferring from)

Dr. Arthur Skalski
151 Hazard Ave #10
Enfield, CT 06082

I hereby authorize and request that my medical records be released **to**: (include name and phone number of doctor you are transferring to)

_____

_____

_____

Records Requested: ___All ___X-ray Reports ___Laboratory reports ___ Consultations
___Other_____

Dates of records requested: From____/_____/_____ to ____/_____/_____

Please indicate if you **Do Not** wish any of the following records to be released:
*Mental Health treatment records, inclusive dates _____to_____
*Drug and/or Alcohol dependency records, dates____to _____
*HIV (AIDS) Antibody test results, dates____ to ____
*HIV (AIDS) Diagnosis and treatment records, inclusive dates _____to_____

- This authorization will be valid for a period of 1 year from the date signed. I understand that I may revoke this authorization at any time by notifying Arthur H. Skalski, MD in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by Arthur H. Skalski, MD is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information to be used or disclosed. I understand there is a charge for copies.
- The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.
- Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

_____ ____/____/____
Signature of Patient or legal Representative Date