Greenwich Internal Medicine
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MEDICAL INFORMATION DISCLOSURE AUTHORIZATION FORM

Date: _____

I, _____, (D.O.B. _____, _____, _____),

hereby authorize Greenwich Internal Medicine to disclose my medical information pertaining to any lab or medical testing, including blood tests, x-rays, EKG, MRI, etc. to:
_____, (State relationship to patient: _____).

If I choose to make any changes to this authorization I know I must contact the office verbally and in writing.

Signature: _____