RECORDS RELEASE AUTHORIZATION

TO: ____

DOCTOR OR HOSPITAL

____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

HARTFORD NEUROLOGY, LLC
85 SEYMOUR ST., SUITE 800
HARTFORD, CT 06106

TEL: (860) 522-4429
FAX: (860) 249-6742

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS
AND/OR TREATMENT DURING THE PERIOD FROM ___________________ TO _____________________

NAME____ DATE ______________________

ADDRESS____

SIGNATURE______________________________ WITNESS______________________________
(IF RELATIVE, STATE RELATIONSHIP)

119-P