MEDICAL RECORD REQUEST (MRR)

PATIENT NAME:	DOB:
GUARANTOR [IF APPLICABLE]:	RELATIONSHIP:
PHONE NUMBER:	DATE OF REQUEST:

RECORD DETAILS: (YOU MUST COMPLETE APPLICABLE SECTIONS BELOW IN FULL:)	
☐	I authorize ____to disclose health information to ____.
	ADDRESS: ____ TOWN:____________________________________ STATE:_______________ ZIP:________________ PHONE: _______________________________________ | FAX: _________________________________
☐	SELF --- HOW WOULD YOU LIKE TO RECEIVE RECORDS?
	☐ FAX (INCLUDE FAX NUMBER)
	☐ MAIL (INCLUDE MAILING ADDRESS)
	☐ PICK-UP (NUMBER TO CALL YOU WHEN PREPARED?)

PLEASE SELECT AT LEAST ONE OPTION BELOW:
☐ DATE RANGE:
☐ SPECIFIC CASE(S)/BODY PART(S):
☐ ENTIRE RECORD:
☐ FINANCIAL HISTORY | ☐ ITEMIZED BILLS | ☐ OTHER:

RELEASE OF SENSITIVE INFORMATION:

I hereby authorize the office selected above to release the records as described above. This authorization is valid for 1 year from the date below.

____ _________________________

Patient/Guarantor Signature: [& relationship] Date:

ECRC STAFF ONLY:	MRR COLLECTED BY: AO | TB | KP | KM | WC | KH
	MRR COMPLETED BY: | ☐ UPD SPREADSHT

☐ LISBON, CT: 2B LEE ROAD | 06351 | Phone: 860-376-2564 | Fax: 860-376-4812

☐ DAYVILLE, CT: [MAILING: P O BOX 425] 165 HARTFORD PIKE | 06241 | PHONE 860-779-0150 | FAX: 860-774-2371