LIFE EXTENSION CENTER
425 MAIN STREET, 2ND FLOOR
RIDGEFIELD, CT 06877
PH: 203.431.6165 FAX: 203.431.6167

Marcie Wolinsky-Friedland M.D. George P. Zabrecky D.C.

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name _____
Last First Middle Initial

Address_____
Street City State

Home Phone_____DOB_____Patient #_____

I,_____, authorize the release of medical information from my medical records to:

- ☐ Dr. George P. Zabrecky and Dr. Marcie Wolinsky-Friedland
- ☐ Myself: _____
- ☐ Other: _____
  Please specify name or organization where records are being sent
- ☐ My Insurance Company:_____

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 limitations as indicated below:

- ☐ Entire Record
- ☐ Specific Information:_____
- ☐ Old Records from Previous Physicians:_____

I give special Permissions to release and information regarding: (initial on applicable line(s) below)

_____Substance Abuse _____ Psychiatatric/Mental Health Information _____ HIV Information
Reason for request

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date_____
If not patient, state relation

Witness_____Date_____