RALPH ROSENBERG, M.D.

EVAN SCHIFF, M.D.

36 East Main St, Avon, CT 06001

MEDICAL INFORMATION RELEASE

I give permission for the following person(s) to obtain information from Dr. Ralph Rosenberg and Dr. Evan Schiff's office regarding my personal medical records, care, and appointments.

Name:____

Relationship:____

Phone Number:____

Is this person your emergency contact?   [ ] Yes   [ ] No

2nd Name If Necessary:____

Relationship:____

Phone Number:____

Is this person your emergency contact?   [ ] Yes   [ ] No

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PATIENT NAME: (PRINT) ____

DOB:____

PATIENT SIGNATURE:____

DATE:_______________________________________   Frontoffice/medinforelease 3/21/16