JENNIFER W. PENNOYER, M.D.
Medical & Surgical Dermatology
Laser & Cosmetic Skin Care

Release of Information

Date of Request: _____

Patient Name: _____ DOB: _____

Patient Address: _____

I authorize the use or disclosure of the above individual's health information as described below:

Release records from: _____
(Provider Name)

_____
(Address)

_____ _____
(Phone Number) (Fax Number)

☐ Entire Medical Records ☐ Pathology Reports

☐ Laboratory Results ☐ Other: _____

Release records to:

Name and Address: _____

_____

Fax Number (if applicable): _____

Please allow 10 business days for processing of this request by the office.

Patient Signature: _____ Date: _____

47 Jolley Drive Bloomfield, CT 06002
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