

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM

Patient's Name _____

Address _____

DOB _____

I, _____ hereby authorize and request :

Physician: _____

Address _____

Release of medical records to:

Maxim Mobility, LLC
90 Hamilton Street
New Haven, CT 06511
Phone 203-772-2445
Fax 203-772-0855

Patient's signature _____ Date _____