Office: 860-848-4180 | Fax: 860-574-9393 • 601B Broad Street | New London, CT 06320

Patient Permission Form

Patient Name:____Date of Birth: ______________________

I authorize Community Therapeutix and employees to release medical information, such as, test results, appointments, and information about medication I have been prescribed to:
*Please circle who we may leave this information with:

Spouse

Children

Parent(s)

Other Family Members (please specify):

____

Other (Please specify):

____

I do not want messages left with anyone other than myself.

____
Signature

I give permission for information to be left on my answering machine. Please check all that apply:

_______ Appointments at Hospital

_______ Appointments with other Physicians

_______ Test Results

_______ Information regarding prescriptions that I am taking or changes in prescriptions

_______ Reminders about upcoming appointments in this office.

Signature:____Date:_______________________

THIS RELEASE REMAINS IN EFFECT UNTIL REVOKED BY PATIENT.