Thomas Cigno, M.D.

Thomas V. Cigno, M.D.
10 South Street Suite 201 | Ridgefield, CT 06877
203-244-7848 | www.CignoMD.com

Request to Release Medical Records

I, the undersigned patient, request a copy of my records:

Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Date of request:_____ Date Records Needed:_____

To: (Name of Provider or Facility): _____

Address: _____

Phone:_____ Fax:_____

Types of records requested:

☐ Treatment Summary
☐ Specific Information:
☐ Procedure report ☐ History and Physical ☐ Physical Therapy ☐ Lab Test Results
☐ X-ray reports ☐ Other:_____
☐ All Medical Records related to a Specific illness or injury

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Please release the requested information to:

Thomas V Cigno, M.D.
10 South Street Suite 201 | Ridgefield, CT 06877
Phone: 203-244-7848 | Fax: 203-244-5111
Records may also be sent via email to info@cignomd.com

Please process this request within 15 calendar days, as provided by law. A copy of this authorization shall be deemed as valid as an original.

I hereby authorize you to furnish the medical information requested to Thomas V. Cigno, M.D., including the results of laboratory tests for infectious disease, if applicable.

_____ _____
Signature of patient or legal representative Date