Michelle van Duinen, APRN

Quiambaug Cove Professional Center

107 Wilcox Road- Suite 105 Stonington, Connecticut 06378 Tel 860-245-5811 Fax 860-245-4752

ddress:	Patient Name:				Date of Birth:			
Chy:								
referred Phone:							_	
I hereby authorize Michelle van Duinen, APRN, PLLC to: Release Protected Health Information from my medical records to: Obtain Protected Health Information from my medical records from ame: Phone/Fax: Difference in the information from my medical records to: Obtain Protected Health Information from my medical records from ame: Phone/Fax: Difference information progress notes, phone calls, labs, consults All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults All medical records only Labs and imaging studies only The following specific info only: wrpose of Disclosure: Coordination of Care School / College Family Member Access to Treatment Coordination of Care Legal (Please specify): Linuderstand that this authorization will expire one year after I have signed this form, or as specified here: Linuderstand that this authorization will expire one year after I have signed this form, or as specified here: Linuderstand that this authorization will expire one year after I have signed this form, or as specified here: Linuderstand that I may revoke this authorization at music the date notified except to the educe duffed been in relance upon it. Linuderstand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protect privacy regulations. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that there may be affer for a copy of my medical record. Linuderstand that information used or disclosee		State:	Zip:					WORK
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