Jeffrey P. Thompsen, MD
Cardiovascular Services
15 Palomba Drive, Suite 4
Enfield, CT 06082
Tel.860-253-9950 Fax 860-253-9398

Release of Records Authorization Form:

Date of request: _____

I _____, request that the office of
Dr. Jeffrey Thompsen to release my medical records to:

Name _____

Address _____

Tele # _____

It is with my signature that I authorize your office to forward any documentation pertaining to my visits.

If you have any questions or concerns regarding the authenticity of this letter please do not hesitate to contact me.

Signature: _____

Date of Birth _____

Social Security # _____