Stefan Topolski, M.D.

1105 Mohawk Trail
Shelburne, Ma. 01370
(413) 625 6240

Consent for Release of Information

I, ________________________________ , authorize ________________________________
(print name) (your prior physician **and** address)

____

and their authorized agents to release my medical records or designated portions thereof as provided below to the following:

Dr. Stefan Topolski
TrailSide Health
1105 Mohwak Trail, Suite 1
Shelburne Falls, Ma 01370
(413) 625 6240 office
(413) 625 6290 fax

____ Complete Record ____ Progress Notes ____ Laboratory Results

____ Treatment Reports ____ Consultant Reports ____ Social Information

____ History & Physical ____ AIDS Testing ____ Substance Use

____ Other(Specify)____

____

Signed________________________________ Date __________ Time ________ am / pm

Print Name ______________________________

Date of Birth ______________________________

If the patient is unable to sign or is a minor, complete the following :
Patient is a minor _____ years of age or is unable to sign because ____________________

____

Next of Kin or Legal Guardian ____

Witness ____

rev. August 15, 2008