



# Fairfield Medical Group, LLC

1300 Post Road • Suite 202 • Fairfield, Connecticut 06824  
• Phone (203) 255-8827 • Fax (203) 259-4610

PETER C. TORTORA, M.D., F.A.C.P.  
EMILY DESTEFANO, PA-C

PETER R. CIMINO, M.D., F.A.C.P.  
ERICA CICCONE, OFFICE MANAGER

## RECORDS TRANSFER REQUEST

TO (Doctor/Hospital): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

**FAIRFIELD MEDICAL GROUP, LLC**  
**Peter C. Tortora, MD    Peter R. Cimino, MD    Emily DeStefano, PA-C**  
**1300 Post Road, Suite 202    Fairfield, CT 06824**  
**Phone (203) 255-8827    Fax (203) 259-4610**

The information I am requesting is: \_\_\_\_\_

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONFIDENTIALITY NOTE

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