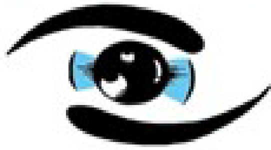

Authorization to Release Medical Records

Patient Name_____________________________ Date of Birth _______________________

This is to authorize you to provide a copy, summary or narrative of my medical records and/or to release confidential information. I understand that my records are electronic. I am requesting the information requested below.

_____________Complete record- $0.75 per page for copies

____________Complete record emailed to ____________________________________

____________Last visit only via Fax sent to ____________________________________

The reason or purpose for this release of information is:

____

I understand that you will provide this information within 30 business days from the receipt of this request, and you may charge a fee as listed above to prepare and furnish this information.

Signed ____________________________________ Date _________________________________

77 Pondfield Road • Bronxville, NY • Phone (914) 337-8844 • Fax (914)-779-5594