PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

CONSENT FOR RELEASE OF MEDICAL RECORDS

You may encounter fees for release of medical records

FOR: Patient's Name: _____
Patient's Address: _____
Patient's Birth Date: _____
Patient's Social Security Number (*last 4 digits only*): XXX-XX-_____

RECORDS REQUESTED FROM:

Practice/Physician Name: _____
Physician Address: _____
Physician Phone #: _____ Fax #: _____

SEND RECORDS TO:

Practice/Physician Name: _____
Physician Address: _____
Physician Phone #: _____ Fax #: _____

Please Check One of the Following:
_____ Send all of my records.
_____ Send only the following records:_____
_____ Send records from (date(s)): _____

PURPOSE/USE OF THE REQUESTED INFORMATION:
Please Check One of the Following:

_____ Insurance Purposes
_____ Transfer of Care (This means you will no longer see the provider that the records are requested from)
_____ Other:_____

PLEASE NOTE: *This authorization includes consent for release of alcohol, drug, psychiatric information, and any information relating to HIV testing, AIDS, and AIDS-Related Syndrome, which may be included in my records. I agree that a copy of this release or a fax of this release shall be as valid as the original. Please send copies of all requested information as soon as possible to the address listed above.*

By signing below, I do hereby consent and authorize you to release copies of my medical records.

Patient's Signature: _____ Date: _____

Witness:_____ Date: _____