1045 West Jericho Turnpike
Smithtown, NY 11787
631-543-8844 Phone
631-543-8840 Fax

RECORD RELEASE AUTHORIZATION

Patient Name:_____ SSN: _____ DOB: _____

Patient Address: _____

I authorize and request the release of my medical records, including medical history, laboratory reports , ultrasounds, and any other material regarding medical consultations and treatment, including information relating to Alcohol and Drug Abuse, Mental Health treatment, except psychotherapy notes, and STD testing, I have received from:

_____ at _____

According to federal and state laws, I do not need to provide an explanation, and the records must be released timely, with no delay. Please forward the records to either myself at the address above or to:

Name: _____
Phone: _____ Fax: _____
Address: _____

o Please release my entire medical record

-or –

o I only request a portion of my medical record to be released to the above. The dates requested are: _____ to _____

_____ _____
Patient Signature Date