Medical Records Release Form

☐ **Middletown Office**
111 Maltese Dr.
Middletown, NY 10940

☐ **Ellenville Office**
112 Shoprite Blvd.
Ellenville, NY 12428

☐ **Liberty Office**
111 Sullivan Ave.
Liberty, N.Y. 12734

In order to ensure that your medical records are held in the utmost confidentiality please be specific as to where you want them sent.

Name: _____ **Birth date:** _____/_____/_____

Address: _____

(Street Name) (City) (State) (Zip)

Home #: _____ **Work #:** _____ **Cell #:**_____

Physician/ Provider: _____

I hereby authorize Middletown Medical to: ☐ release or ☐ obtain my health information to/from:

Name: _____ Phone #:_____ Fax: _____

Address: _____City:_____ State: _____ Zip: _____

Reason for transfer: _____

(a)Specific information to be released:

☐ Medical Record from (insert date)_____ to (insert date)_____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____
_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information.

(b)☐ By initialing here _____ I authorize _____
(initials) (Name of individual health care provider)

MIDDLETOWN MEDICAL
Your health care… all in one place!

To discuss my health information with my attorney, or a governmental agency, listed here:

_____

∗This authorization will expire on (insert date or event):_____

∗I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, it will not have any effect on any actions that the Practice has already taken in reliance on this authorization.

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

_____ _____

(Signature of patient or patient's representative) (Date)

PLEASE SPECIFY IF YOU WANT CD OR PAPER RECORDS. CD will be $5.00 as per New York State Law.

∗There will be a .75 cent charge per page for all requested medical records.

Phone: (845) 341-0037 Fax: (845) 341-0026

(845) 341-0024 (845) 341-0005