MIDDLETOWN MEDICAL
Your health care… all in one place!

Medical Records Release Form

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**