

Family Medicine Medical Records Release

I hereby authorize Family Medicine Associates of Ithaca, NY to RELEASE or OBTAIN my medical record information as specified below:

Patient Name: _____ D.O.B. _____

I authorize Family Medicine to RELEASE copies of my records TO:

Name of Physician or Institutions, etc.

Address

City, State, Zip Phone/Fax Number

Dates of treatment for which you need records.

I authorize Family Medicine to OBTAIN copies of my records FROM:

Name of Physician or Institution, etc.

Address

City, State, Zip Phone/Fax Number

Dates of treatment for which you need records.

***** PLEASE CHECK ALL THAT APPLY:**
****Information to be Released:**
 Office Notes
 Radiology Results (X-rays, CT Scans, MRI, Ultrasound, etc.)
 Lab Results
 Immunization Records
 Other: _____

PLEASE SEND REQUESTED RECORDS TO:

ATTENTION: MEDICAL RECORDS
Family Medicine Associates of Ithaca
209 West State Street
Ithaca, New York 14850
Telephone: (607) 277-4341
Fax: (607) 277-1506

Information will be used /disclosed for the following purpose(s):

Routine Healthcare Operations

Treatment

Payment (Insurance companies, etc.)

Pending Appointment Date: _____

Other: _____

Authorization Valid for: (check one)

This request only

One year from date of this authorization OR _____ (insert data).

I understand that routine requests typically take 7 – 10 days to process.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient

Office Staff: Promptly forward to Medical Records and provide a copy of this completed form to the patient.