NEW WINDSOR
Family Medicine

CONSENT/AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name_____

Address_____ **City**_____ **State**____

Zip Code_____ **Phone**_____ **Date of Birth**_____ **SSN**_____

Other Name(s) Under Which Your Were Treated:_____

Records Released From:
Name: _____
Address: _____
_____
Telephone _____ Fax _____
Attn: _____(point-of-contact)

Records Released To:
New Windsor Family Medicine
575 Hudson Valley Ave.. Ste. 201
New Windsor, NY 12553
Telephone: (845) 220-2270 Fax (845) 220-2277
Attn: Medical Receptionist (point-of-contact)

*Telephone*_____ *Fax*_____

INFORMATION TO BE RELEASED

( ) Complete copy of all records ( ) Progress notes ( ) Lab reports
( ) Radiology reports ( ) Immunization records
( ) Correspondence ( ) Billing information ( ) Other (specify)_____

For the following dates:_____

By initialing below I authorize the release of the following:

_____Mental Health Treatment/Evaluation ____HIV/AIDS Related Information
_____Drug Treatment/Evaluation ____Alcohol Treatment Evaluation

Reason for disclosure

____Further medical care ___Insurance claim ___Insurance application
____Legal Investigation ___Personal ___Other

This authorization will remain in effect until this request is processed, unless you specify that it will be effective for an additional time period. Written consent is necessary to revoke this request.

_____Additional time period (specify)
_____ Include future records during time period ___None

I authorize release of my medical records as described above. I understand that I have the right to inspect the disclosed material. A photocopy of this consent shall be valid as the original.
I have had an opportunity to read the Information Guidelines of Medical Record Disclosure.

_____
Printed Name of Patient

_____ _____
Signature Patient/Guardian **Date**

If signed by person other that patient, state relationship and authority to sign.

_____ _____
Relationship **Authority**