AUTHORIZATION TO RELEASE MEDICAL RECORDS

This document must be signed by the patient or person authorized by law.

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release a copy of medical records for: (Health Care Provider)

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Transmission by FAX means authorized to expedite transfer of records. Fax #518-786-9241

Release Medical record to: **Lucie Capek, MD, PLLC**

 **1003 Loudon Rd, Suite 101, Latham, NY 12047**

By initialing spaces below, I authorize the release of the following records:

\_\_\_\_ Complete medical records (all information listed below). The recipient understands the entire record may be large and agrees to pay all reasonable copy changes.

\_\_\_\_\_ All Hospital/Institutional records (including nursing records/progress notes)

\_\_\_\_\_ Transcribed hospital/institution records (includes surgical reports, history & physical exams, consultation, discharge summary reports).

\_\_\_\_\_ Laboratory reports

\_\_\_\_ Pathology reports

\_\_\_\_ Diagnostic imaging reports

\_\_\_\_ EKG/Cardiac reports

\_\_\_\_ Physician/Occupational therapy reports

\_\_\_\_ Physician office/clinical notes

\_\_\_\_ Implant information

\_\_\_\_ Photographs

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or gurdian, if minor

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Witness