Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records you would like to inspect:

☐ All records
☐ All records between the dates of _____ and _____.
☐ Records pertaining to _____.

Please specify what records you would like to copy:

☐ All records
☐ All records between the dates of _____ and _____.
☐ Records pertaining to _____.

Please specify method of release:

☐ Pick-up
☐ Certified Mail to:

***Please note: As permitted by New York State law, a fee will be charged for the cost of copying records and mailing. In addition, if X-Rays or other information must be reproduced or records are lengthy such that the costs will be significant, we reserve the right to request a deposit.**

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

Patient/Guardian Signature: _____ Date: _____

(If other than patient, cite authority and attach proof if applicable _____)

Internal Use Only:

Completed By: _____

Date Records Mailed/Picked-up: _____

Fees for Copying and Mail:_____