

ADVANCED ORTHOPEDICS

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MEDICAL RECORDS RELEASE REQUEST

Patient Name _____ Date of Birth _____

Address _____

Phone _____

Please provide copies of:

____ Entire Medical Record

____ X-Ray/MRI Reports(describe) _____

____ Other _____

Send above requested records to:

Name _____

Address _____

Telephone# _____

Please Note: There is a fee of \$0.75 per page, plus postage. There is fee of \$10.00 for each X-Ray and MRI disc which must be pre-paid. Please complete all information including full mailing addresses. Incomplete information may result in the return of your request. Requests may take up to 30 days for completion.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

Records sent on _____

285 SILLS ROAD, BLDG. 18, PATCHOGUE, N.Y. 11772 · 64 COMMERCE DRIVE, RIVERHEAD, N.Y. 11901

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