ADVANCED ORTHOPEDICS

285 Sills Rd, Bldg 18, Patchogue, NY 11772

MEDICAL RECORDS RELEASE REQUEST

Patient Name____________________________________ Date of Birth______________

Address ____

Phone ____

Please provide copies of:

___ Entire Medical Record: please specify in which format you would like to receive it:

___Paper copy ___Electronic format (disk)

___ Radiological Studies (indicate exam type and date)___________________________

___Image on disk only ___Report on paper only ___Image and Report

___ Other ____

Send above requested records to:

Name ____

Address____

____

Telephone#____

Please Note: There is a fee of $0.75 per page, plus postage. Please complete all information including full addresses. Incomplete information may result in the return or delay of your request. We will try to provide this information within 14 business days, however, please allow up to 30 days if there are extenuating circumstances delaying the process.

Patient/Guardian Signature _____________________________ Date _________________

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FOR OFFICE USE ONLY:

Records sent on ____