Suburban Rheumatology/Suburban Medical Group

8207 Main Street, Suite 7 & 8
Williamsville, NY 14221
(716) 626-4200 (phone) & (716) 626-4201 (fax)

Authorization to Release/Obtain Medical Records

I authorized Dr. _____, to release/obtain my health information to/from the following physician/facility.

Name of Physician/Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____

The following information is for purpose of treatment:

___ Entire Medical Record

___ Medication List

___ CT, MRI, or X-ray, results of _____ from (date)_____

___ Labs from (date)_____

___ Progress notes from (date)_____

___ Other

I understand that I have the right to evoke this authorization at any time. If I revoke this authorization, it must be done in writing. I understand that this authorization will expire in 1 year or on a date or condition in which I specify. This authorization will expire on the following date: _____.

Patient name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Phone: _____

Signature of Patient: _____ Date:_____

If signed by a Legal Representative, Relation to Patient: _____

Signature of Witness: _____ Date: _____