Brockport Vine Medical
Phone number #:585 391 3040
Fax :585 625 0070
Office Address
122 West Ave Suite #6 B,Brockport , NY 14420

MEDICAL RECORDS RELEASE REQUEST

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #:_____ PHONE #:_____

THE FOLLOWING FACILITY IS AUTHORIZED TO PROVIDE COPIES OF THE PATIENT'S IDENTIFIABLE HEALTH INFORATION:

RELEASE FROM:

NAME:_____

ADDRESS:_____

PHONE #:_____ FAX #:_____

SEND TO:

NAME: Alex Fahoury,MD

ADDRESS: 122 West Ave, Ste.6 Brockport, NY 14420

PHONE #: 391-3040 FAX #: 585-625-0070

PURPOSE FOR RELEASING THE INFORMATION

☐ MOVING AWAY FROM AREA ☒ TRANSFER OF CARE ☐ AT PATIENTS REQUEST ☐ CONTINUATION OF CARE

INFORMATION TO BE RELEASED

☐ OFFICE / TREATMENT NOTES ☐ LABS ☐ IMAGING (XRAY, CT, MRI) ☒ EKG ☐ OTHER _____

PLEASE INDICATE THE DATES OF SERVICE TO BE RELEASED

☐ ENTIRE MEDICAL RECORDS FOR SERVICES RENDERED AT THIS OFFICE

☒ LAST OFFICE NOTE, LABS, AND / OR X-RAY TEST RESULTS

☐ OTHER (PLEASE SPECIFY)_____

I UNDERSTAND THAT IF MY RECORDS CONTAIN DOCUMENTATION OF ALCOHOL ABUSE, PSYCHIATRIC CONDITION, DRUG ABUSE, OR COMMUNICABLE DISEASE, THIS INFORMATION WILL BE RELEASED AS PART OF MY RECORD.

I UNDERSTAND THAT IF THE PERSON OR FACILITY RECEIVING THIS INFORMATION IS NOT COVERED BY FEDERAL PRIVACY REGULATIONS, THIS INFORMATION WILL NO LONGER BE PROTECTED AND MAY BE RE-DISCLOSED.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, BUT REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED.

NOTE: THE REVOCATION MUST BE IN WRITING AND DELIVERED TO THE ABOVE ADDRESS OF THE PERSON / ENTITY OF WHOM WAS TO RELEASE INFORMATION.

I UNDERSTAND THAT UNLESS EARLIER REVOKED, THIS AUTHORIZATION WILL EXPIRE 30 DAYS AFTER THE DATE SIGNED.

I UNDERSTAND THAT THERE MAY BE A CHARGE FOR OBTAINING THE REQUESTED INFORMATION, RELATED CHARGES CAN BE OBTAINED BY CONTACTING THE MEDICAL RECORDS DEPARTMENT.

I UNDERSTAND THAT I HAVE THE RIGHT TO OBTAIN A COPY OF THIS AUTHORIZATION.

PATIENT SIGNATURE :_____ **DATE:**_____

PATIENT PRINTED NAME:_____