Adult Medicine & Pain Management

1 Pinnacle Place, Ste. 203, Albany, NY 12203
Phone: 518-438-4700, Fax: 518-438-3190

Medical Record Release Request

This form has to be filled out and placed in the patient's medical record if copies are requested

This release expires one year from the date signed

Date: ______________ Patient's Name: ____

Date of Birth: ____

Records To Be Sent To:

Name/Organization: ____

Address: ____

Phone #: ______________________ Fax #: ______________________

Purpose of Requesting Records: ____

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Types of Records Requested (Please Check All That Apply):

- ☐ Consents & Agreements
- ☐ Demographics
- ☐ History (including Social & Family)
- ☐ Progress Notes
- ☐ Diagnostics & Labs
- ☐ Procedure Notes
- ☐ Phone Calls & Triage Notes
- ☐ Super & E Bills
- ☐ Medication List & History
- ☐ Consults
- ☐ Misc. Correspondence
- ☐ Mental Health Records
- ☐ HIV Records
- ☐ Other (Please Specifiy)

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Signature Of Patient Or Legal Representative

Copies: 75 Cents Per Page

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www.adultmedicinepc.com