springlife medical
creating health

Phone: 631-647-9100 Fax: 631-647-9099

Medical Record Release Form

Patient's Full name: ______________________________ DOB: ___________

Address : ___________________________ City : ____________ State : ___ Zip : ________

Phone Number : _______________

I hereby grant the following entity/doctor's office permission to release information contained in the medical record of the above named patient (please print the name of the doctors/specialist who currently possess your medical information)

____

Information requested : ____

Restrictions and/or exclusions : ____

Purpose of Release :

The purpose of this release is to provide my primary care physician with details of my medical history.

The information described above is to be released directly to my Primary care physician at :

Springlife Medical
1111 Montauk Hwy Ste 2-4
West Islip, NY 11795
Phone : 631-647-9100 Fax : 631-647-9099

I hereby authorize my doctor/specialist named above to release any medical information as requested above. This may include information about drug/alcohol abuse, psychiatric, social work, or other protected information unless otherwise excluded. I am aware that my medical information will not be released without a valid signature below.

Signature of Patient : __________________________________ Date : __________
Signature of parent or guardian : ___________________________ Date : __________