



REQUEST FOR MEDICAL RECORDS

PATIENT REQUEST FOR THE RELEASE OF MEDICAL RECORDS

I, the undersigned Patient (and/or Legal Representative), would like to review following patient records (Specify the patient name and a description of the records requested (including any applicable dates):

Patient Name: _____

Description of records requested: _____

I would like copies of these records. *

I would like copies of my records sent to the following address:

Signature: _____ Print Name: _____ Date: _____

If someone other than the patient requests access to patient records, please describe below the relationship of the requestor to the patient:

In accordance with the New York Public Health Law §17 and 18, enacted in 1991, our charge for the photocopying of these records is seventy five cents (\$.75) per page for copying fees, plus an extra fee for special mailing requirements. All requests must be sent to the Central Business Office to the attention of Kaitlin McEnergy Medical Record Clerk for processing. If you have any questions please call Kaitlin at 631/580-5200.

Site Location: _____