PARKMED NYC

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby request that you release to:

❑ Self Address _____

❑ Physician _____

❑ Legal Counsel _____

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____ to _____.

Date Requested _____ Patient Signature _____

Date of Birth _____ Patient Chart Number: _____

I understand that there is an administrative fee of 0.75 cents per page. Additionally, I will be responsible for the cost of mailing the records certified, return receipt, which is a minimum of $5.21. I understand that payment is due prior to the release of my records.

Office Use Only

Received By: _____ Request Approved By: _____

Administrator Signature _____Date_____

Physician Signature _____Date_____

Date Chart Released:_____

800 Second Avenue, 6th Floor, New York, NY 10017
800-346-5111 212-686-6066