ALDEN MEDICAL GROUP

12845 BROADWAY

ALDEN, NY 14004

P716-937-3255 F 716-204-7481

Patient Name: ____ DOB______________________

All current records are stored electronically and will be burned to a CD for a flat fee of $15.00. If you require your medical records be printed the following fees will be applied.

Fees: I understand that I am responsible to pay a fee of $0.75 per page plus postage for any release of medical records. This is in accordance with Public Health Law section 17. A copy of this section will be provided upon request.

Please check the appropriate request: ______Most recent Office visit, EKG, Labs and radiology studies.

_______ Last 1 yr. __________ Last 5 yrs. ____________Entire medical record.

Please do not include the following information:

________ Chemical/ alcohol dependence ____ Mental Health information ______ HIV testing

I hereby authorize Alden Medical Group PLLC 12845 Broadway Alden NY 14004

__________ To release my records to:

Name: ________________________________

Address: ____

Fax # ___________________________________

__________ To obtain my records from:

Name ______________________________________

Address____

Fax #_______________________________________

Signature: ____ Date :__________________________

This request will expire 6 months following the date of the signature. I can cancel this authorization at any time.

Dje/Eff 2/19/09 updated 6/29/15