EAST AURORA FAMILY PRACTICE

MEDICAL RECORD RELEASE REQUEST

PATIENT NAME: _____

CURRENT ADDRESS:
_____
_____
_____
_____

DATE OF BIRTH: _____

I REQUEST AND AUTHORIZE YOU TO RELEASE MEDICAL RECORDS TO:

EAST AURORA FAMILY PRACTICE LLP
112 OLEAN ROAD; SUITE 220
EAST AURORA, NY 14052
OFFICE 716-805-1072 FAX 716-805-1073

MEDICAL RECORDS ON THE ABOVE PATIENT ARE BEING RELEASED TO EAST AURORA FAMILY PRACTICE FROM:

DOCTORS NAME AND ADDRESS:
_____
_____
_____
_____

PATIENT SIGNATURE:_____**DATE**:_____

GUARDIAN SIGNATURE:_____**RELATIONSHIP**:_____

THIS RELEASE EXPIRES SIX (6) MONTHS FOLLOWING THE DATE OF SIGNATURE. I CAN CANCEL THIS AUTHORIZATION BEFORE THAT TIME.

rev 6/04