170 Intrepid Lane
Syracuse, NY 13205

Phone:315-671-2500
Fax: 315-671-5050

CONSENT TO RELEASE MEDICAL INFORMATION

Patient:_____ **Date of Birth:** _____

Physician Releasing Records:

Name_____

Address_____

City_____ **State**_____ **Zip**_____

Physician/Person To Receive Records:

Name_____

Address_____

City_____ **State**_____ **Zip**_____

Records Requested For:

____ Transfer of Care

____ Continuity of Care

____ Moving Out of the Area

Medical Information to be Sent:

____ Medical Record, INCLUDING information related to cardiology, cardiac testing, lab results.

____ ENTIRE Medical Record, INCLUDING information related to treatment for substance abuse or dependency, psychiatric or mental health treatment, testing or treatment of sexual transmitted diseases and HIV/AIDS

____ Record of care from _____ to _____ dates

If deemed necessary by Dr. Hana Rohan, I authorize this information to be sent via fax transmission.

This applies to all information in my medical record protected under the regulations of 42 Code of Federal Regulations, part 2.

_____ _____

Patient or Legal Guardian's Signature **Date**