



Compassion, Confidence and Commitment for over 50 Years www.scarsdalemedical.com

Authorization for Release of Medical Record Information

To request release of medical information, please complete and sign this form and return it to:

Scarsdale Medical Group, LLP
Health Information Department
550 Mamaroneck Avenue, Suite 302
Harrison, NY 10528

Patient Information

Last Name _____ First Name _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Telephone _____

Information Requested (please be specific and enter dates of service if known): _____

Restrictions and Any Exclusions

Medical Records are to be released to the following:

Name _____ Telephone _____

Street Address _____

City _____ State _____ Zip _____

•If you are requesting medical records to be released into your personal care (self), please be aware that there is a .75 cents charge per page.



Acknowledgement

I hereby authorize Scarsdale Medical Group to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, revoke this authorization at any time, except to the extent that Scarsdale Medical Group has acted upon it. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.

Medical Records copying fees: \$0.75 per page
No fee if released to another Doctor

I understand that Scarsdale Medical Group, LLP will continue to provide care, even if I do not authorize this release.

Signature of Patient

Date

Signature of Parent or Guardian (if patient is a minor)

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA)