Scarsdale Medical Group | White Plains Hospital

Authorization for release of medical record information from an outside physician

Patient Information:

Last Name_____First Name_____Date of Birth_____/_____/_____

Street Address_____

City_____State_____Zip_____

Telephone (H)_____(W)_____(C) _____

I,_____, am under the care of Scarsdale Medical Group. I hereby authorize the provider named below to transfer my medical records to the Scarsdale Medical Group doctor and location as indicated.

(Please fill in the name and the complete address of the outside facility and provider from whom information is being requested)

Doctor _____ Practice Name _____

Street Address _____

City _____ State ____ Zip _____

Phone Number _____ Fax Number _____

Please send the requested information to Scarsdale Medical Group to the attention of:

SMG Physician: _____

Address: _____

Phone: _____ Fax: _____

Description of information to be enclosed:

☐ All records ☐ Immunization Records

Dates of treatment:

Other:

Reason for requested Information disclosure:

☐ Transfer of health coverage ☐ Personal Use ☐ Form Completion ☐ Referral ☐ Change of healthcare provider

_____ _____

Patient signature Date

_____ _____

Signature of patient representative Date

259 Heathcote Rd, Scarsdale NY 10583
550 Mamaroneck Ave, Suite 101, Harrison NY 10528
600 Mamaroneck Ave, Suite 102 / 200 / 301, Harrison NY 10528
T (914) 723 - 8100 F (914) 219 – 1933 WWW.SCARSDALEMEDICAL.COM