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 medical provider from whom the 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:

Doctor _____ at _____

Scarsdale Medical Group - Health Information Department
600 Mamaroneck Avenue, Suite 200, Harrison, NY 10528

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