MEDICAL RECORD RELEASE REQUEST

Patient Name: Date Of Birth:

Address:

City: State: Zip Code:

I request and authorize you to release ALL medical record to:

Dr.

Amherst Medical Associates, LLP
6000 N Bailey, Amherst New York 14226
Phone716-834-4266 Fax 716-834-6255

Medical records on the above patient are being released to Amherst Medical Associates from:

Name of Facility:

Address:

City: State: Zip Code:

Phone: Fax:

Patient Signature: Date:

Guardian Signature: Relationship:

This release expires 1 year following date of signature. I can cancel this authorization before that time. If client is between 12 years and 18 years of age, both client and parent must sign consent.

5/09-njm