AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please make sure all blanks are filled in; failure to do so may prevent or delay release of information. It will take 7-10 business days to process.

I HEREBY AUTHORIZE SOUTHERN NEW YORK NEUROSURGICAL GROUP, P.C. TO RELEASE MEDICAL RECORDS FOR:

Patient Identification

Name: _____
Street: _____
City:_____State:_____Zip:_____
Phone:_____
SS#:_____DOB:_____
Maiden/Previous Name: _____

Provider (Who will be releasing Information and how?)

CIRCLE ONE: Dr. Bajwa Dr. Galyon Dr. Sethi

CIRCLE ONE: FAX MAIL PICKUP

Requester (Where is the information being sent?)

Name: _____
Street: _____
City:_____State:_____Zip:_____
Fax #: _____

Information Requested or to be Viewed

_____ Office Visit Notes (DATE FROM:__/__/__- TO PRESENT)
_____ Operative Notes
_____ Film Reports (x-rays, MRI"s, CT's, etc.) ___Lab Data___EKG
_____ All

Reason for Release

_____ Consult- Continued medical care
_____ Legal
_____ Leaving the Practice
_____ Other _____

Release Valid: (expires after 1 year)

I understand that this authorization will expire 1 year following the date of signature and may be revoked by request at any time. This authorization includes information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV related test, HIV infection, HIV related illness, AIDs or any information which could indicate potential exposure to HIV. I understand that the information to be released from the medical records is confidential and protected from disclosure. Southern NY Neurosurgical Group, P.C. is not authorized to disclose any medical information which was obtained from other providers/facilities. Southern NY Neurosurgical Group, P.C. is not legally responsible for any disclosure that may arise from requested information.

Signature of Patient or Legal Representative: _____ Date:_____
Relationship if not signed by Patient: _____

Office Use Only

Signature of Witness: _____Address of Witness: 46 Harrison Street, Johnson City, NY 13790
Date records sent: _____ Initials: _____

*Southern New York Neurosurgical Group, PC will provide one (1) copy of medical records to the patient or provider free of charge. Multiple copies will cost $0.75 per page. If records are requested for multiple providers, the records will be provided to the patient to distribute accordingly.