NORTH COUNTRY ENT, PC.
2 MOUNTAIN LEDGE DRIVE
GANSEVOORT, NY 12831
518-587-6610 fax 518-226-0890

REQUEST FOR RELEASE OF MEDICAL RECORDS BY PATIENT

THIS FORM MUST BE ACCOMPANIED BY OCA OFFICAL FORM NO: 960 "NYSDOH AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA"

PATIENT NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED IN ACCORDANCE WITH THE ATTACHED FORM #960.

PATIENT OR
GUARDIAN SIGNATURE:_____Date:_____

If medical records are to be released to another health care provider/insurance company for the ongoing care of the patient, there will be no charge for copying the medical records or conveying them to the other health care provider.

If medical records are to be released to a non-health care provider/insurance company, the charge for copying the documents as follows:

Paper copies at $0.75/page
Number of pages:_____ $_____
Postage: $_____
Total Amount Due: $_____
Payment Received on: _____

Upon receipt of the above fees, copies of the patient's medical record will be forwarded to the party indicated.

Records Released on:_____By:_____