



MEDICAL RECORD RELEASE FORM
Tel: (845) 896-1659 (Voice Mail) Fax: (845) 231-5647
Email: medicalrecords@mhmipc.com

Date of Request: _____

Patient Name: _____ DOB: _____

Address: _____

Tel # _____ Primary Care Physician: _____
(Day Time Phone Number)

Send medical information to:

Name of Person or Entity to Receive Information

Title (Physician, Therapist, Attorney)

Street Address

City, State and Zip Code

Reason for Request: (Check Box)

- I am leaving the practice
- I am seeking a specialist and my appointment is _____.
- I am seeking health/life insurance.
- I am seeking disability benefits.
- Other _____.

Records requested:

- All Medical Records
- Immunizations & physical examinations
- Radiology Report , Films or CD
- Specific records from _____ to _____
- Mammography _____ / _____
(Date) (Date)
- Ultrasound of _____ / _____
(Body Part) (Date)
- CT Scan of _____ / _____
(Body Part) (Date)
- MRI of _____ / _____
(Body Part) (Date)

I understand that if I request a copy of my medical records for personal use the fee is \$.75 per page. There is no charge for a Radiology CD, but \$5.00 per page for copies of Radiology films.

√ _____
Patient Signature

Date

MRT Completed

Date

Executive Review

For MHMG Use Only (If patient is requesting records for personal use)

Pages _____ x \$.75 = \$ _____

Payment method: { } Please make check payable: Mid Hudson Medical Group
{ } Credit Card: Please call (845) 231-5551 to arrange payment