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Pediatric ENT • Nasal & Sinus Disorders Center • Allergy Testing & Treatment • Facial Plastic Surgery • Snoring & Sleep Disorders
Voice, Speech & Swallowing • Hearing Loss, Tinnitus & Balance • Cochlear Implants • Head & Neck Surgery • Skull Base Surgery
Thyroid & Parathyroid Surgery • CT Scan Imaging Services

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ **MR#:** _____ **DOB:** ____/____/_____
Print

Address: _____
Print

Phone: (____)_____

I, _____ hereby request the release of my medical records as listed below:
Patient Signature

□ Entire Medical Record

□ Medical Records for these dates: _____ to _____

□ Hospital Consultation Notes □ Operative Notes

□ Other (Please Specify

_____

____Please Send Records to: _____ Please obtain records from:

_____

Phone: (_____)_____ Fax: (_____)_____

____ Please send me a paper copy of my records:
□ I will pick these up at the Albany Office of Albany ENT & Allergy Services.
□ Please mail to my home address indicated above.

____ Please send an electronic version of my record in the format indicated:
□ Disc (CD) □ Email: _____

Expiration Date of Authorization

☐ This authorization is effective through _____/_____/_____(insert date) or

☐ No Expiration unless revoked or terminated by the patient or the patient's personal representative.
Please note you can terminate or revoke this authorization at any time by contacting our HIPAA compliance officer.

If you have any questions about this request, please contact Medical Records at 518 701 2088.
A nominal fee may be charged for the labor of copying, whether in electronic or paper form and for supplies for creating a paper copy or electronic media if requested on portal media. If for any reason any part of this request is denied, the patient and or patient representative will be informed as to the reason for such denial.