Arthur Weinreb, DPM
77 Quaker Ridge Road, Suite 104
New Rochelle, NY 10804
Phone (914) 636-2363
Fax 914) 636 7781

MEDICAL RELEASE OF RECORDS

I hereby request a copy of my medical records for___ myself or for ____ review by another provider. I understand that this information is confidential and will only be released as specified in this authorization.

I also understand that by making this request, any information contained in my medical record will also be released to the specific party.

I understand the provider is **allowed to charge me a photocopy fee of $25.00 max. 35 pages,** and that this fee is payable in advance.

PATIENT INFORMATION (please print clearly)
Name:_____

Address: _____

Phone #_____ Date of Birth_____

INFORMATION TO BE RELEASED TO:

Provider Name:_____

Provider Address: _____

Provider Phone # _____

INFORMATION TO BE RELEASED FROM

Arthur Weinreb, DPM
77 Quaker Ridge Road, Suite 104
New Rochelle, NY 10804
(914) 636-2363 Phone
(914) 636-7781 Fax

SIGNATURE OF PATIENT OR LEGAL GUARDIAN AND DATE RELEASE

_____