Alessi Vascular Surgery, PC

Christopher Alessi, M.D.

Medical Record Release

Patient Name: _____ Date of Birth: _____
(Please print)

Social Security No: _____

Authorization for medical information regarding the above patient to be released.

From: _____
Name

_____
Street Address

_____
City State Zip Phone#

To: _____
Name

_____
Street Address

_____
City State Zip Phone #

Purpose for release: _____

Information Requested to be released:

Chart Notes: _____ Hospital Records: _____
Radiology Results: _____ Lab Results: _____
Itemized Billing: _____ All Records: _____

I hereby consent to release the above stated information.

Signature: _____ Date: _____

Relationship to Patient: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Signature: _____Date: _____

Relationship to Patient: _____

This authorization is valid for 1 year from date of signature and may be revoked at any time by written request.

Date Mailed or Faxed: _____ Date Hand Carried: _____

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