ALLEN-MCMONIGLE
MEDICAL ASSOCIATES

1045 W. Jericho Turnpike, Smithtown, NY 11787
Tel: 631-543-8844 Fax: 631-543-8840
www.allen-mcmoniglemedical.com

To: _____ Date: _____

Phone: _____

Fax: _____

RECORD RELEASE AUTHORIZATION

Patient Name: _____ SSN: _____ Birth: _____

Patient Address: _____

I authorize and request the release of my medical records, including medical history, laboratory reports, ultrasounds, and any other material regarding medical consultations and treatment I have received from _____ at _____.

According to federal and state laws, I do not need to provide an explanation, and the records must released timely, with no delay. Please forward the records either myself at the address above, or to:

Dr. Marc Allen
Dr. Jennifer McMonigle
1045 W. Jericho Turnpike
Smithtown, NY 11787

O Please release my entire medical record.

or

O I only request a portion of my medical record to be release to the above. The dates requested are _____ to _____.

_____ _____
Patient Signature Date

_____
Print Name