St Lawrence Health Alliance, Inc.
3 Lyon Place, Ogdensburg, NY 13669
Phone: 315-394-7542 Fax: 315-394-8995

MEDICAL RECORDS RELEASE FORM

To:________________________________ Date:_______________________

Name of Doctor or Institution Expiration:__________________

____
Address
____

I hereby authorize the release of my general medical records. Nature of information to be released:

Check which apply:
________ Most recent immunizations, labs, progress notes or all.
________ Furthermore, I authorize the release of my medical records pertaining to psychiatric, drug and/or alcohol abuse issues.

Released to:
____
Doctor or Institution name
____
Address
____

__________________________________ X__________________________________

Patient's Name Printed Patient or Legal Representative's Signature

____

Patient's Address X __________________________________
__________________________________ Witness' Signature

__________________________________ Date:_______________________________

Patient's Date of Birth