MUHAMMAD A. WATTOO, MD, FACP
INTERNAL MEDICINE OF ITHACA, PC
2359 N. Triphammer Rd, Ithaca, NY 14850 ◊ Phone: 607.257.3452 ◊ Fax: 607.257.3612

RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

I authorize the following organization to disclose above named individual's health information:

Name: Internal Medicine of Ithaca, PC Phone/Fax: 607-257-3452 / 257-3612 (fax)

Address: 2359 N. Triphammer Rd Ithaca, NY 14850

The type and amount of information to be disclosed is as follows:

Dates of services from (date) _____ to (date) _____

- ☐ Labs: _____
- ☐ X-ray and imaging reports
- ☐ EKG, ECHO, Stress test, Cardiac Cath
- ☐ Immunization Record
- ☐ Entire Record
- ☐ Recent Hospitalization Record
- ☐ Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

The information may be disclosed to and used by the following individual or organization:

Name: _____ Phone/Fax: _____

Address: _____

for the purpose of: ☐ Continued Healthcare ☐ Personal ☐ Other: _____

Note: A copying fee will be charged on requests for purposes other than patient care.

I understand I have the right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization shall be in effect for one year from this date.

Delivery instruction(s):

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

Request Processed on: _____ by: _____