



Scott A. Edison, M.D.
Theodore J. Koh, M.D.
John H. Sun, D.O.
Margaret M. Bailey, M.D.
Rayees Nizam, M.D.
Thomas C. Lee, M.D.
Christine M. Granato, M.D.

Qun Xu, N.P.
Kathryn D. Alder, N.P.
Chelsey R. Brooks, PA-C
Karen R. Patnode, N.P.
Melanie K. Davis, N.P.

Patient Authorization for Release of Medical Records

Patient's Name: _____

Address: _____

DOB: _____

Please check all information that applies:

- Chart Notes
- Lab Results
- X-rays/CAT Scans/MRI/MRA
- Procedure/Pathology Reports
- Other (Please Specify)

I give my authorization to Dr: _____ at fax# _____

to release the above protected information to: _____ fax# _____

- I am authorizing to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:

Name: _____

Address: _____

Fax #: _____

Select one of the following choices:

- This authorization will end on the following date: _____
- This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

Signature of Patient: _____

Name of Patient: _____

Date: _____

Township 5 Medical Park
260 Township Blvd, Suite 20
Camillus, NY 13031
315-708-0190 Fax 488-3284

Northeast Medical Center
4217 Medical Center Drive
Fayetteville, NY 13066
315- 329-7300 Fax 329-7308

North Medical Center
5100 W. Taft Road, Suite 3C
Liverpool, NY 13088
315- 452-2214 Fax 452-2217

4939 Brittonfield Parkway
Bldg. B, Second Floor, Suit209
East Syracuse, NY 13057
315- 218-0085 Fax 218-0087