



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY
UPSTATE CARDIOLOGY**

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DATE: _____

PATIENT'S FULL NAME: _____

ADDRESS: _____

DOB: _____ SS# _____

RELEASE RECORDS TO: _____

PLEASE SEND A COPY OF MY RECORDS AS INDICATED FOR THE

DATE(S) OF TREATMENT: _____

____ OFFICE NOTE ____ EKG ____ PROCEDURE

OTHER _____

PURPOSE OF RELEASING MEDICAL INFORMATION: _____

Signature of Patient, Parent
or Legal Guardian

Witness