



DAVID S. ORENTREICH, MD

CATHERINE A. ORENTREICH, MD

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AUTHORIZATION FOR RELEASE OF RECORDS FROM ORENTREICH

Patient's Name:	MedRec Number: (to be filled out by office)		
This authorization will not be accepted unless all items are completed. 1. The authorization becomes effective upon signing and will expire on (date) If no date is indicated, this authorization will expire 1 year from signing date. 2. The information being disclosed may include office notes, consultation and treatment notes, correspondence, phone messages, medications, and test results, for the period from to 3. The following information will not be released unless the patient authorizes it by initialing below: HIV/AIDS records, including test results Drug/Alcohol abuse and mental health treatment records 4. The information is to be released to: (Name of person or facility and address)			
		5. Reason for request:(Information is disclosed for the follow	ving purpose)
		6. Format in which you would like to receive the reco	rds: Paper copy Electronic copy (CD)
		The released information may be subject to re-disclolonger be protected by the privacy rules.	sure by the party receiving the information and may no
			time, in writing, signed by you. Such a revocation shall reliance on your prior authorization. Your treatment or the signing of this authorization.
		As set forth by Public Health Law 17 & 18, the fee fo \$10.00 per photo. The copy of the records will be pro-	or the copies of medical records is \$0.75 per page; photo is ovided within 10 business days.
The copies can either be picked up in person or email copies of medical records.	mailed to the address noted above. We do not fax or		
chooses to send someone else to pick up the record name. The person will be asked to show picture ID a	at the front desk by the patient in person. If the patient ds, the release of records should be made to that person's t the time of pick up. ess stated on this Authorization form. We will charge you		
7. Signature of patient or legally authorized represen	tative: Date:		
8. Name and relationship to legally authorized repres	sentative to patient:		