



MEDICAL RECORD RELEASE REQUEST

Patient Name:

Date Of Birth:

Address:

City:

State:

Zip Code:

I request and authorize you to release ALL medical record to:

Dr.

**Amherst Medical Associates, LLP
6000 N Bailey, Amherst New York 14226
Phone 716-834-4266 Fax 716-834-6276**

Medical records on the above patient are being released to Amherst Medical Associates from:

Name of Facility:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Patient Signature:

Date:

Guardian Signature:

Relationship:

This release expires 1 year following date of signature. I can cancel this authorization before that time. If client is between 12 years and 18 years of age, both client and parent must sign consent.

5/09-njm