Allergy Asthma and Sinus Center of Long Island
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Release of Medical Records

From: *Harshit M Patel MD* To: ________________________________

120 Bethpage Road, Ste 310 ________________________________

Hicksville, NY 11801 ________________________________

P: 516-822-6655 F: 516-932-2090

I, ______________________________________, authorize the release of medical information from Dr. Harshit M. Patel, MD to healthcare provider above for the purposes of review. This release is authorized for one year from the date of signing and all information will be regarded as confidential.

Please forward the following:

_x_ Complete medical history, diagnosis and treatment records

_x_ X-ray, MRI, CT, US reports

_x_ X-ray, MRI, CT, US copies and reports

_x_ Laboratory findings

_x_ Exam findings and diagnosis

_x_ Treatment notes

_x_ All allergy records and tests

Please include records from ______________ to the present. Thank you for your prompt attention in this matter.

____
Print Patient Name

__________________________________ __________________________________
Patient Signature Provider Signature

__________________________________ __________________________________
Patient D.O.B Date