Pillar Medical Associates, PC

1500 Portland Avenue
Rochester, NY 14621
585-697-6416
Fax: 444-3280

URGENT

Release of Information (we will send to current primary care physician)

_____ _____
Name of Patient Patient's Date of Birth

Patient has appointment on _____. We need records for continuity of care.

PERMISSION IS HEREBY GIVEN TO: _____
(your MD name here) _____
_____
Phone:_____
Fax:_____

To Release Information to: Pillar Medical Associates, P.C.
1500 Portland Ave
Rochester, NY 14621

TYPE OF RECORDS/INFORMATION REQUESTED:

- Immunizations: (Influenza, vaccination, Pneumovax, tetanus, and PPD results)
- Problem list
- Medication List
- Any Hospital Discharge Summaries
- Recent blood tests and other diagnostic tests
- Progress Notes from recent office visits (within last 6-12 months)
- Advance Directives/Healthcare Proxy
- Other (_____)

Mental Health and alcohol/drug treatment records are not included unless you complete the following section giving us specific permission to do so.
The records requested may include (circle): Mental Health Treatment Records
Alcohol/Drug Treatment Records

I understand that my consent to release/obtain information will expire 90 days or (_____), not to exceed one year. Initials: _____

I understand that I may withdraw this consent in writing at any time. Initials:_____

_____ _____
Patient's Signature Sponsor (if patient cannot sign)

_____
Date
Patient Address and Phone Number:_____