AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **Hudson Valley Radiologists** *P.C* to **RELEASE** my **DRA Imaging** *P.C* medical records as described herein to the following:

Patient Name: _____

Street Address: _____

City/State/Zip: _____

Date of Birth: ____/_____/_____ **Phone Number:** (_____) _____

Release records to the following:

Self: ☐

[OR]

Name: _____

Street Address: _____

City/State/Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Records: _____

Dates: _____

Signature of Patient: _____**Date**:_____

Please print name clearly: _____

DRA Imaging *P.C* medical requests for October 15, 2015 and prior will be processed.

Please Fax to HVR Medical Records at 845-293-6038 or drop off/mail to:

Hudson Valley Radiologist, PC

ATTN: Medical Records

2678 South Road

Suite 202

Poughkeepsie, NY 12601

Any questions please call: 845-790-6979

Employee Initials: _____

Date:_____