Dr. Ralph Viola, MD
1157 Fairport Road, Suite 201
Fairport, NY 14450
(O) 585-586-9900 (F) 585-586-7700

Authorization to Release Medical Information to Another Practice

Date ___________________

Patient Name________________________________Date of Birth____________________

Patient Address____

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Dear Dr. Viola,
Please release my medical records including office notes, tests, and any document/s which pertains to my continual care. Excluding:

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To:____

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(P)______________________________________ (F)_____________________________

Phone and fax are required.

This request will expire in 1 year from the date signed.

____ _____________

Signature Date

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Relationship to patient (if not signed by patient)