TOTAL FAMILY CARE
Dr. Hylton Lightman, Medical Director

Medical Records Release Form

Patient Information:

Patient Name:_____

Address:_____

Patient Date of Birth: _____/_____/_____ Phone Number: _____

Request Release From:

Name of Practice: _____

Doctor(s) Name:_____

Address: _____

Phone Number:_____ FAX: _____

Email: _____

I hereby authorize you to release to Total Family Care of the 5 Towns and Rockaway a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

Signature: _____ Date: _____
(Parent/Guardian if Patient is Minor/Patient if Age 18 +)

Print Name _____

Please Include the Following:

_____ Sick Visits	_____ Laboratory
_____ Well Child Visits	_____ Operative Reports
_____ Hospitalizations	_____ Radiology Reports
_____ Immunizations	_____ Consultation Reports
_____ Growth Charts	_____ Other _____

Remarks: _____

601 Jarvis Avenue Far Rockaway NY 11691
Office PHONE 718-868-4808 - Office FAX 718-868-2270
www.totalfamilycaremd.com