

Release of Medical Records
DOT Physical & Family Health
Rachel Raven FNP-C
Physical: 137 E Main St Mailing: PO Box 361
Gouverneur NY 13642
Phone: (315) 323-7360
Fax: (315) 216-3545

I, _____ (name) request that my medical records be released to DOT Physical & Family Health.

Patient DOB: _____

Patient full address: _____

Patient phone number: _____

Please release the following information:

____ Copy of last office note & last office note addressing: _____

____ Copy of last set of labs, specifically hemoglobin A1c, other _____

____ Copy of last set of diagnostic studies, specifically _____

Other: _____

Please release records from: _____

Unless otherwise specified authorization is valid 90 days from signature below. Other: _____

Please release records to:

DOT Physical & Family Health Rachel Raven FNP-C PO BOX 361 Gouverneur NY 13642

Fax: (315) 216-3545.

Patient name (printed)

Patient signature & date

Witness name (printed)

Witness signature & date