

AMHERST PEDIATRIC ASSOCIATES
25 Hopkins Road • Williamsville, NY 14221
716-632-8050 (phone) • 716-632-2297 (fax)

MEDICAL RELEASE AUTHORIZATION FORM

TO: _____
Previous Physician or Hospital

Address

City/State/Zip

I hereby authorize and request you to release to:

AMHERST PEDIATRIC ASSOCIATES
25 HOPKINS ROAD
WILLIAMSVILLE, NEW YORK 14221

The complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Patient Name: _____ DOB: _____

Address: _____

Signature Date