Arlington Central School District
Office of Human Resources

144 Todd Hill Road
LaGrangeville, NY 12540
845-486-4460

MEDICAL INFORMATION/RECORDS RELEASE AUTHORIZATION

Patient's Name _____ Date of Birth _____/_____/_____

Social Security Number _____ Home Phone _____

Address (street, city, state) _____

_____

Please release my information and/or medical records from:

Name of provider _____

Provider's address _____

_____

Provider's telephone number _____

Release of information and/or medical records to:

TEK Medical Services
Dr. Andrew Weber
1075 Route 82, Suite 10
Hopewell Junction, NY 12533

I hereby authorize the above named provider to discuss my medical condition with the physician named above who represents the Arlington School District. I also authorize my physician to release any records requested by said physician, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays. Additionally, I give permission to Dr. Anderson to speak with the Arlington Central School District about my medical condition.

_____

Patient's Signature Date

Please send copies to:

-Your physician
-Roberta Kaiser rkaiser@acsdny.org, 144 Todd Hill Rd, LaGrangeville, NY 12540