RECORDS REQUEST

Name:____ **Date of birth:**_______________

Street Address: _________________________________ **Phone:**____________________

City: ____________________________________

State/Zip:________________________________

The above patient was treated in your office in the past. Patient has scheduled an upcoming appointment with our office. In order to provide continuation of care, please forward patient's records to fax #: (716) 707-3935.

PLEASE FAX OR SEND COPIES OF:

☐ All medical records from _______________ to _______________

☐ Partial medical records from _______________ to _______________, including:

☐ Office Notes
☐ Lab Results
☐ Imaging Results
☐ Alcohol and/or Substance Abuse
☐ Pregnancy / Reproductive
☐ Mental Health
☐ Sexually Transmitted Diseases
☐ HIV-Related
☐ Genetic Testing
☐ Other, details _______________________________
____
____

I also authorize AVP Primary Care, PLLC to discuss my health information as listed above verbally, if needed.

____ ___________________

Signature of Patient / Legal Guardian Date

AVP Primary Care, PLLC

6631 Main Street, Suite 2, Williamsville, NY 14221

Phone: (716) 706-8984 Fax: (716) 707-3935