Revised on 02/12/2016

Vilensky Upstate Medicine, PC

Phone: (585) 267-7700 Fax: (585) 267-7536

MEDICAL INFORMATION RELEASE CONSENT

Date:_____/_____/_____

Name:_____

Address:_____

_____

DOB:_____/_____/_____ □ Male □ Female Phone: ( )_____

Name of Institution/Office: _____

Address of Institution/Office:_____

_____

Phone Number: ( ) _____ Fax Number: ( ) _____

Release medical information to: **Leonid Vilensky, MD**

INFORMATION REQUESTED:

» Medical History/Mental Health Information

» Pharmacy Records

» Imaging Reports/Films

» Alcohol or drug use

» HIV/AIDS – related information

For the purpose of: □ Pain Treatment □ Substance Dependence Treatment

This consent form will remain in effect until the day you withdraw your consent (in writing).

I understand that I sign this form voluntarily and that I may change my decision at any time. Although I understand that I cannot do anything about information previously authorized and released, I am aware that I must notify Rochester Physician PLLC/Vilensky Upstate Medicine in writing if I would like to revoke this release. A copy of this form is as valid as the original.

Authorizing Signature: _____ Date:_____/_____/_____

Revised on 02/12/2016

Date Faxed:______/______/______

Processed By:____