Revised on 9-7-17

Vilensky Upstate Medicine, PC
Leonid Vilensky, MD
141 Sully's Trail, Suite 3
Pittsford, NY 14534
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, 141 Sully's Trail, Suite 3, Pittsford, NY 14534**

INFORMATION REQUESTED: Medical History/Mental Health (**LAST 2 – 3 OFFICE VISITS ONLY)**

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:_____/_____/_____

Date Faxed:_____/_____/_____

Processed By:_____