Transfer of Records Request

Date: _____

To (name of physician):_____
Address: _____
Phone: _____
Fax: _____

I hereby authorize the release of my entire medical record or specific parts of same, notably_____, and request that you forward these copies to:

Island Medicine
210 East Main Street
Huntington, NY 11743
(p) 631-757-9500
(f) 631-757-2325

Lorraine F. Burns, MD
Patrick B. Burns, MD

Thank you in advance for your attention and prompt response to this request.

Patient Name (printed): _____
Patient DOB: _____
Patient SSN: _____

Patient Signature: _____