COMPREHENSIVE OCCUPATIONAL MEDICAL SERVICES, P.C.
Gordon C. Steinagle, D.O., M.P.H.

RECORDS RELEASE AUTHORITY

NAME: _____

DATE OF BIRTH: _____ SS#: _____

I hereby authorize and request Comprehensive Occupational Medical Services to release to:

_____

_____

_____

The complete medical records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Please send the following:

- ☐ CHEST X-RAY (FILMS AND REPORTS)
- ☐ ALL MEDICAL RECORDS
- ☐ BLOOD/URINE TEST RESULTS
- ☐ OTHER: _____

SIGNED: _____ DATE: _____

WITNESS: _____ DATE: _____

51 Webster Street • North Tonawanda, New York 14120
P: (716) 692-6541 • F: (716) 692-7091

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