RECORDS RELEASE AUTHORIZATION

TO: ____

____

____

PHONE #: __________________ FAX#: __________________

I, ____________________________ REQUEST THAT YOU RELEASE
(parent or guardian)

MY, MY CHILD(REN) RECORDS TO :

DR. CHRISTOPHER BENEY, M.D., P.C.
77 ELIZABETH DRIVE
LOCKPORT, NY 14094

PHONE # 716-433-2674 **FAX # 716-433-2677**

PATIENTS NAME ____________________________ DOB ____________

PATIENTS NAME ____________________________ DOB ____________

PATIENTS NAME ____________________________ DOB ____________

PATIENTS NAME ____________________________ DOB ____________

PATIENTS NAME ____________________________ DOB ____________

PATIENTS NAME ____________________________ DOB ____________

PATIENT'S OR GUARDIAN'S SIGNATURE ______________________

DATE ____________________________