RECORDS RELEASE/REQUEST

TO____

ADDRESS__________________________________

CITY__________________STATE____ZIP________

I hereby authorize the release of my _______________________

or copies of such and request that they be transferred to:

Dr. Robert Videyko
128 State Street
Newburyport, MA 01950
Tel: (978) 465-1500
FAX (978) 465-7501

____
Print name of Patient

From:__________________To:______________________________
Date of Records

____
Patient's Signature   Date