PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION:

(please print clearly)

Name:_____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZATION FOR RELEASE:

(Please complete the name and address of the Facility from which we are requesting prior records)

I hereby authorize:

Facility Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

to release, disclose and forward copies of my medical records, diagnostic images and clinical reports as well as pathology and cytology findings, if appropriate, for services performed during the time period dating from _____ to _____

to:

SCHAFFER, SCHONHOLZ & DROSSMAN, LLP

488 Madison Avenue Suite 1220 New York, NY 10022

Tel. 212-755-7656 Fax: 212-755-0283

Please send records to the attention of the physician specified below.

- ❒ Richard Schaffer, M.D
- ❒ Lyris Schonholz, M.D.
- ❒ Susan Drossman, M.D.
- ❒ Elizabeth Thomson, M.D.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____