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:

SCHONHOLZ and 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:

- ❑ Dr. Lyris Schonholz, M.D.
- ❑ Dr. Susan Drossman, M.D.
- ❑ Dr. Elizabeth Thomson, M.D.
- ❑ Dr. Keren Tuvia Baron, M.D.

Patient's Signature: _____ Date: _____