PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Requesting Records FROM: _____

PHONE: _____

FAX: _____

Records Needed: _____

_____

I hereby authorize and request that you release my complete history and medical records in your possession concerning my illness and/or treatment.

PATIENT INFORMATION
NAME:_____
DOB: _____SS#:_____
ADDRESS:_____
_____

I hereby authorize release of my medical records to

Dr. Sonia A. Talwar / Dr. Edgar M. Mendizabal

_____

PATIENT'S SIGNATURE

(Authorization to Release Medical Records)

PLEASE SEND RECORDS TO:

SONIA A. TALWAR, M.D / EDGAR M. MENDIZABAL

ENDOCRINOLOGY, DIABETES & METABOLISM, NY P.C.

1097 Old Country Road, Suite 102

Plainview, NY 11803

Phone: (516) 931-1007

Fax: (516) 931-1008