DOWNTOWN WOMEN
OB/GYN ASSOCIATES, LLP

Records Release Authorization

Date: _____

Dear Dr. _____,

(Office Address: _____

Phone: _____ Fax:_____)

I hereby authorize you to release my complete medical records to:

Downtown Women OB/GYN, LLP
568 Broadway – Suite 304
New York, NY 10012
PH: 212-966-7600
FX: 212-925-8736

Thank you.

Please Print:

Name:_____

Date Of Birth:_____

Social Security #:_____

Address:_____

Phone:_____

Signature:_____ Date:_____

Note to patients:
If there is a portion of the medical records that you do not wish released to Downtown Women, you must indicate this in writing in the space below.

_____

_____

_____

_____

_____

Patient Signature:_____ Date:_____