TEL 212.348.4000

DATE: _____/______/______

I ____ HEREBY REQUEST MY RECORDS FROM MY
(Print Name/Date of Birth)

PERSONAL FILE TO BE RELEASED TO:

☐ My Doctor via Fax:

Name: ___________________________

Address: _________________________

____

City________State______ ZIP: ______

Phone # (____)________________

Fax #( )_____________________

☐ □ Upper West Side (55 Central Park West)

Myself:

Name: ___________________________

Address: _________________________

____

City________State______ ZIP: ______

Phone # (____)________________

☐ Pick Up Location

□ Lower Manhattan (65 Broadway 14th Floor)

□ Staten Island Center (1550 Richmond Ave)

□ Brooklyn Center (118 3rd Avenue)

Patient (sign):___________________________________

Patient Associate (sign):___________________________________

*****DISCLAIMER: Medical record requests can take up to 10 business days to be processed. If your last visit to our office is over two years, processing times will be longer.**