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.

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Patient Signature:______________________________ Date:________________