AUTHORIZATION TO RELEASE RECORDS
PURSUANT TO NYS PUBLIC HEALTH LAW SECTION 18

To:____
(Doctor or Hospital where Records are located)

Address____

____

Phone Number_____________________Fax Number_____________________

I hereby authorize and request you to release medical records in

your possession for____,
(patient name)

including x-rays, and ________________________________ test results.

Please MAIL to the following office:

Dr. Eva Turner
10 East 704th St
Orangeburg NY 10962

Phone Number 845-359-5599

Patient Name ________________________________

Date__________________Patient Signature_____________________________

Witness_________________________ Relationship_______________________

CONFIDENTIALITY AND PATIENT PRIVACY NOTICE: If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action based on the confidentiality contents of this information, except it's direct delivery to the intended recipient named above, is strictly prohibited. If you have received this request in error, please notify us immediately by phone to arrange for the return of the original documentation.