MEDICAL RECORDS RELEASE AUTHORIZATION

Patients Full Name

DOB

Address

City/State

Zip

Phone

Email

I HEREBY AUTHORIZE AND REQUEST YOU RELEASE A COMPLETE COPY OF MY MEDICAL RECORDS TO:

- ◯ John Zhang MD, MSc, PhD
- ◯ Jennifer Kulp- Makarov, MD, FACOG
- ◯ Khaled Zeitoun, MD

Name, Address, Phone and Fax of Physician from whom you are requesting records:

Patient Signature or Patient's Designated Representative

Date

Print name (if different from Patient's)

SPECIFIC UNDERSTANDINGS: BY SIGNING THIS AUTHORIZATION FORM, YOU AUTHORIZE THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE. YOU UNDERSTAND THAT ONCE THE INFORMATION IS DISCLOSED PURSUANT TO THE AUTHORIZATION, THE INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NOT BE PROTECTED BY FEDERAL PRIVACY REGULATIONS (IF THE RECIPIENT IS NOT REQUIRED BY LAW TO PROTECT THE PRIVACY OF THE INFORMATION). YOU HAVE A RIGHT TO SEE AND REQUEST A COPY OF THE INFORMATION DESCRIBED ON THIS AUTHORIZATION FORM IN ACCORDANCE WITH HOSPITAL POLICIES. YOU ALSO HAVE A RIGHT TO RECEIVE A COPY OF THIS FORM AFTER YOU HAVE SIGNED IT.

4 Columbus Circle,
New York, NY 10019