MANHATTAN

WOMEN'S HEALTH

Authorization to release healthcare information

Patient Name: _____ Date of Birth: _____

I request and authorize Manhattan Women's Health to release the confidential healthcare information of the patient named above to:

Name: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

The purpose of this release of information is: _____

I would like this information to be:

☐ Faxed ☐ Mailed ☐ Available for Pick-up

Printed Name: _____ Signature: _____

Date: _____

For Office Use Only:

Received Date: _____ Completed Date: _____ Signed: _____

Notes:

993 Park Avenue, New York, NY 10028 | www.manhattanwomenshealth.net | Phone 212-744-6700 | Fax 212-744-6799