TRIBECA

WOMEN'S HEALTH

Authorization to release healthcare information

Patient Name: ___________________________________ Date of Birth: _____________________

I request and authorize Tribeca 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 ☐ Emailed

Printed Name: ____________________________ Signature: ___________________________

Date: _______________________

For Office Use Only:

Received Date: _________________ Completed Date: ___________________ Signed: ___________

Notes: