

WESTCHESTER HEALTH ASSOCIATES, PLLC

60 Goldens Bridge Road

Katonah, NY 10536

914-232-1919

Fax: 914-401-8053

RECORDS RELEASE AUTHORIZATION

TO: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize and request the above Doctor/Facility/Hospital to release records to:

Name: _____

Address: 60 Goldens Bridge Road
Katonah, NY 10536

Please send the complete history records in your possession concerning my illness and/or treatment during the period:

From: _____ To: _____

All records: _____

PATIENT NAME: _____
(PLEASE PRINT CLEARLY)

DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Witness: _____ Date: _____