Dr. Laura Heisler 6 Aspen Rd, New Rochelle NY 10804 914-235-1971

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 FAX or MAIL (circle one) to the following office:

Dr. Laura Heisler
6 Aspen Rd
New Rochelle NY 10804

Phone Number 914-235-1971 Fax Number 914-235-1971

Patient Name _____

Date_____Patient Signature_____

Witness_____ Relationship_____