

**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 \_\_\_\_\_

CONFIDENTIALITY AND PATIENT PRIVACY NOTICE: If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action based on the confidentiality contents of this information, except it's direct delivery to the intended recipient named above, is strictly prohibited. If you have received this request in error, please notify us immediately by phone to arrange for the return of the original documentation.