Authorization for Release of Patient's Medical Information

Dr. Aaron Spingarn
141 South Central Avenue – Suite 100
Hartsdale, NY 10530
914-686-3950

PATIENT NAME _____

DATE OF BIRTH _____

STREET ADDRESS _____

TELEPHONE # _____

S.S.N # _____

I hereby authorize the Medical Records Department Staff of Dr. Aaron Spingarn to release information from my medical record to:

_____

_____

Fax#_____

_____
(SIGNATURE OF PATIENT/ REPRESENTATIVE/ OR LEGAL GUARDIAN)

_____
(DATE)

_____
(IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT)