Elevated Health NYC

315 Madison Avenue • Suite 801

New York, NY • 10017

Medical Records Release Form

Patient Name: Date of Birth:

Address: Phone:

Records Requested from:

Name (Doctor's Office):

Doctor's Office Fax #:

Date(s) of Service:

Records Needed:

Fax Records To:

Attn:

Fax To: 917-997-9457

I, ____________________________(patient name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity.

________________________________ ______________________

Printed Name Date

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Signature