739 Irving Ave, Suite 530
Syracuse, NY 13210
Phone: (315) 478-1158
Fax: (315) 478-3014

Authorization for Release of Medical Information

I, Name (please print)____D.O.B.____________
authorize: Physician/Facility Name____
Address____
Phone___________________________ Fax______________________

To release the pertinent medical records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records.

To: Chantell Dalpe, MD	The Women's Wellness Place
Kristen Kratzert, MD	739 Irving Ave. Suite 530
Stephen Cohen, MD	Syracuse, NY 13210
Annemarie Dixe, NP at	Phone: (315) 478-1158
	Fax: (315) 478-3014

I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.
Patient/Guardian signature_____________________________ Date _______________________

OR

I, Name (please print)____D.O.B.____________
authorize **The Women's Wellness Place** to release the pertinent medical records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name_______________________________
Address____
Phone___________________________ Fax______________________

I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.
Patient/Guardian signature_____________________________ Date _______________________