WESTSIDE | CARDIOLOGY

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Suite 503
New York, NY 10019
Phone: 212-765-0765
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CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's name____

Date of Birth__________________ SSN_________________________________

Address____

Date(s) requested____

I authorize:

142 West 57th Street
______________________________________ 142 West 57th Street__________
Suite 503
New York, NY 10019
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To release my medical records to:
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HIV test results will not be sent unless specifically requested:

_____Yes, forward HIV test results _____DO NOT forward HIV test results

Signature_____________________Relationship to patient________________________

Witness___________________________________