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RECORD RELEASE

New York State law requires all patients requesting the release of their medical records to give permission in writing. Permission to release HIV related records to any person, company or institution must also be specifically requested in writing.

By completing this form, I authorize the release of my medical records, including any HIV test results, from _____.
(previous practice)

Name: _____

Date of Birth _____

Please release my records to:

Village Obstetrics
1225 Park Avenue
New York, NY 10128

I understand that my entire chart with all of my records will be moved to Village Obstetrics practice.

Signature: _____ Date: _____
