RECORDS RELEASE AUTHORIZATION

To _____
(Doctor or Hospital)

_____
Address

I hereby authorize and request you to release to:

PARK EAST GYNECOLOGY & SURGERY
DR. TAMER SECKIN
572 5TH AVENUE
NEW YORK, NY 10065
212-583-1444

The complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____

Name _____ Date _____

Address _____

Signature _____ Witness _____
(If relative, state relationship)