RECORDS RELEASE AUTHORIZATION
from Downtown Primary Care, LLP

PATIENT (please print)_____

_____

DOB_____**SS#**_____

My current address:_____

_____

Home Phone:_____**Work Phone:**_____

Please release my medical records as described below and forward them:

FROM: **DOWNTOWN PRIMARY CARE, LLP**
726 Broadway, Suite 351, New York, NY 10003
Tel: (212) 992-9198 Fax: (212) 995-4627

TO: _____
name

_____
address

_____ _____
phone **fax**

☐ **All of my records in your possession, excluding records from other facilities.**

☐ **All records concerning my treatment for the specific condition(s) as follows:**

_____

☐ **All records concerning treatment provided between the following dates:**

_____**and**_____

Signature:_____**Date**_____