CROSSPARK MEDICAL, PLLC
200 West , 86th Street Suite 1i
New York, NY 10024

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name____
Patient's Address ____
Patient's date of Birth ____
Patient's Social Security Number ____

TO: ____
____
____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records form other practices and practitioners, hospitals and / or clinics, which are a part of my medical records. Please send copies of all requested information as soon as possible to the address listed below.

- SEND ALL OF MY RECORDS
- SEND RECORDS FROM (DATE) _________________ TO (DATE) _____________
- SEND MY RECORDS PERTAINING TO ___________________________________

____ Change of PCP ______ Continued care

SEND RECORDS TO:
______ PAUL J. CHRZANOWSKI, MD _____ KATHERINE A. HAWKINS

CROSSPAK MEDICAL, PLLC
200 West , 86th Street Suite 1i
New York, NY 10024
212.873.1840; 212 873. 1487

____
Patient's Signature
____
Date
____
Witness