

Authorization for Release of Medical Information

authorize: Physician/Facility Name Address Phone Fax To release the pertinent medical records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records. To: Chantell Dalpe, MD The Women's Wellness Place Kristen Kratzert, MD 739 Irving Ave. Suite 530 Stephen Cohen, MD Syracuse, NY 13210 Annemarie Dixe, NP at Phone: (315) 478-1158 Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature Date OR I, Name (please print) OR J.O.B. authorize The Women's Wellness Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature Date	I, Name (please print)	D.O.B
Address PhoneFax	authorize: Physician/Facility Name	
To release the pertinent medical records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records. To: Chantell Dalpe, MD Kristen Kratzert, MD Stephen Cohen, MD Annemarie Dixe, NP at I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form. Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	Address	
To release the pertinent medical records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records. To: Chantell Dalpe, MD Kristen Kratzert, MD Stephen Cohen, MD Annemarie Dixe, NP at I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form. Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	Phone	Fax
sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records. To: Chantell Dalpe, MD Kristen Kratzert, MD Strephen Cohen, MD Annemarie Dixe, NP at Phone: (315) 478-1158 Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) OR I, Name (please print) OR J.O.B. authorize The Women's Wellness Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.		
records. To: Chantell Dalpe, MD Kristen Kratzert, MD Stephen Cohen, MD Annemarie Dixe, NP at I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) OR I have in the women's Wellness Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	To release the pertinent medical rec	ords in your possession, such as office notes, mammograms,
To: Chantell Dalpe, MD	sonograms, bone density tests, bloo-	dwork, pathology/cytology, operative notes and any other pertinent
Kristen Kratzert, MD Stephen Cohen, MD Syracuse, NY 13210 Annemarie Dixe, NP at Phone: (315) 478-1158 Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) OR I, Name (please print) D.O.B. authorize The Women's Wellness Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.		
Stephen Cohen, MD Annemarie Dixe, NP at Phone: (315) 478-1158 Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) OD.O.B. authorize The Women's Wellness Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.		
Annemarie Dixe, NP at Phone: (315) 478-1158 Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature OR I, Name (please print) Address Place to release the pertinent medical records in your possession, suc as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	Kristen Kratzert, MD	
Fax: (315) 478-3014 I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature	Stephen Cohen, MD	
I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature	Annemarie Dixe, NP at	Phone: (315) 478-1158
signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form. Patient/Guardian signature		Fax: (315) 478-3014
I, Name (please print)	expiration. I may request a copy of	this form. Date
as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name	I. Name (please print)	-
as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, operative notes and any other pertinent records to: Physician/Facility Name	authorize The Women's Wellness	Place to release the pertinent medical records in your possession, such
notes and any other pertinent records to: Physician/Facility Name Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.		
Address Phone Fax I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.		- 4 - · D1
I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	Address	· <u> </u>
I understand that this authorization to release information will expire one year from the date of my signature on this form and I may revoke authorization at any time in writing before the date of the expiration. I may request a copy of this form.	Phone	Fax
Patient/Guardian signature Date	I understand that this authorization is signature on this form and I may revexpiration. I may request a copy of	to release information will expire one year from the date of my voke authorization at any time in writing before the date of the this form.
	Patient/Guardian signature	Date