**City Care Family Practice, P.C.**
160 East 32nd Street Suite 102
New York, NY 10016-6871
Tel 212-545-1888
Fax 212-545-1919

_____/____/_____
(Date of Request)

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**To**: _____
(Previous Primary Care Physician / Specialist)

Phone: _____ Fax: _____

I, _____, _____/_____/_____,
(Print Name) (Date of Birth: MM/DD/YYYY)

Hereby request that you release to:

**City Care Family Practice, P.C.**
160 East 32nd Street, Suite 102 New York, NY 10016
TEL: (212) 545 - 1888
FAX: (212) 545 - 1919

**Medical Records pertinent to your treatment of me from ____/____/____ to ____/____/____:**

☐ Doctor's note related to the follow treatment or condition only: _____

☐ Laboratory Test Results

☐ Immunization Records

☐ HIV related Records (additional authorization required)

☐ All medical records, including any records related to:
Sexually Transmitted Disease, Drug and Alcohol Abuse Treatment and Mental Health or Mental Illness.

☐ Other (Please specify): _____

_____
(Patient's Signature)

_____
(Address)

_____ _____ _____
(City) (State) (Zip Code)