RECORDS RELEASE AUTHORITY

TO: _____

_____

I, _____ hereby request that
(Patient's name or guardian)

you release to:

ZEV ASH, M.D., F.A.A.P.
Pediatric and Adolescent Medicine
413 Marlborough Road
Cedarhurst, New York 11516
Telephone: (516) 569-5404

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____ to _____.

_____ (Date of Request)

_____ (Patient's Signature)

_____ (Witness)

_____ (Address)

_____ (Date)

_____ (City, State, Zip Code)