

Spring Ob/Gyn, PC

Heidi Flagg,MD • Brina Maldonado,MD • Cara Dodson,MD • Rachel Friedman,MD • Marie Easterlin,MD • Danielle Feldman,MD
Bonnie Yim, CNM • Lauren Lese, CNM

RECORDS RELEASE

This form must be filled out in its entirety before we can comply with record requests.

New York State law requires all patients requesting the release of their medical records to give permission in writing. Permission to release HIV related records to any person, company or institution must also be specifically requested in writing.

By completing this form, I authorize the release of my medical records, including any HIV test results, from Spring Ob/Gyn P.C.

Name: _____

Date of Birth: _____

Are you transferring your care out of our office? Yes No

If you only require specific reports or results, please specify which ones below:

Please release the records to (chosed one):

- Myself
- Dr. _____
- Other third party: _____

I would like my records to be (chosed one):

- Picked up in person at the office
- Mailed to the following address: _____
- Faxed to (____) _____ - _____

Attn: _____

Signature: _____ Date: _____

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I, _____ authorize the release of my complete medical records to Spring Ob/Gyn, PC. My complete medical record includes all progress notes and HIV test results.

Please release my records to:

Spring Ob/Gyn, PC
135 Spring Street, 2nd Floor
New York, NY 10012
Fax: 212-219-1538

Signature: _____ Date: _____