



Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

S.S. Number: _____ Telephone Number: _____

I request and authorize to release my healthcare information to:

Baher Yanni M.D. Tolga Kapusuz M.D. Edward Alexeev M.D. Alexander Pekurovsky M.D.
Amanda Morris PA-C Payal Patel PA-C Hye Min Kim APN
Carmen Cheng PA-C Alexa Nappi PA-C

FAX records to 609-371-9110

I specifically request the following records authorized for release:

- | | |
|---|--|
| <input type="checkbox"/> Last three operative reports | <input type="checkbox"/> Initial Office Visit |
| <input type="checkbox"/> Procedure Flow Sheet | <input type="checkbox"/> Medication Flow Sheet |
| <input type="checkbox"/> Any CT, MRI or X-RAY report | <input type="checkbox"/> Last three office visit reports |

OR

- All my records

Patient Name: _____

Patient Signature: _____

Date: _____