GREENWICH VILLAGE GYN, P.C.
GENNADIY A GRIGORYAN, M.D., FACOG
314 West 14th Street, 4th Floor
New York, NY 10014
Phone: (646) 964-4904 Fax: (917)261-6467

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

1. Regarding Patient ***COMPLETE IN FULL***

Name - Last, First, MI		
Street Address		Telephone #
City	State	Zip Code
	Birthdate	

2. Records Released From

Name - (i.e. Health Facility, Physician...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released To

Name – (i.e. Health Facility, Physician…)		
Street Address		
City	State	Zip
Phone #	Fax #	

☐ These records are needed for an appointment on ___________. ☐ I would like to pick up copies, call me when ready.

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

- ☐ Complete Copy of All Records
- ☐ X-ray Reports/Films
- ☐ Women's Clinic Visits/Labs Only
- ☐ Lab Reports
- ☐ Visit notes of _________________________

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☐ Further Health Care ☐ Insurance/Claims ☐ Application for Insurance
☐ Legal ☐ Personal ☐ School Disability
☐ Academics ☐ Other:____

6. I authorize release of my health records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

7. Signature of patient____ **Date**_______________________
(If signed by person other than patient, state relationship and authority to do so.)

Release Date: ______________ #Pgs ________ Certified: Y N Via: Mail Fax Pick up Completed by Initials ______