CoreHealth Medical Care, PLLC
247-39 Jamaica Avenue
Bellerose, NY 11426
PH: 718.343.2045
FAX: 718.343.2088

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

I hereby authorize you to release medical records of:

_____
(Patient Name)

_____
(Date of Birth)

Please mail medical records to:

CoreHealth Medical Care, PLLC
247-39 Jamaica Ave
Bellerose, NY 11426
Or Fax to: 718.343.2049

Information Needed:

- **_____ All Records**
- **_____ Hospital Stay**
- **_____ Hospital Discharge Summary**
- **_____ Immunizations Only**
- **_____ Laboratory**
- **_____ Operative Report**
- **_____ Pathology Report**

_____ _____
Signature of Patient Date