Benjamin F. Asher, M.D.
RESTORATIVE ENT

Records Release Authorization:

Request to
(physician's name): _____

Today's Date: _____

Request from
(patient's name): _____
last name first name middle initial

Patient's date of birth
or social security number: _____

I hereby request that you release to:

Benjamin F. Asher, M.D.
127 East 61st Street, Ground Floor
New York, NY 10021
Phone: 212-223-4225
Fax: 212-223-6465

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

_____
Signature of patient

If patient is a minor, parent / guardian must sign and date below:

_____
Signed Date

Please print name of signatory above: _____