BETH ISRAEL MEDICAL CENTER

2011

AUTHORIZATION FOR RELEASE/PATIENT ACCESS OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____ S.S. #: _____ M.R. #: _____

Street, Apt. #: _____

City, State, Zip Code: _____ Telephone #: _____

1. I hereby authorize the Medical Records Department staff at Beth Israel Medical Center to release information from my medical record to (If self please indicate below):

2. Name _____

   Address _____

   City, State, Zip Code _____ Telephone #: _____

   For the purpose of *(please check one)*

   ☐ Continued Treatment ☐ Legal Review ☐ Insurance purpose

   ☐