AdvAnced SurgicAl PhySiciAnS

Andrew J. Shapiro, MD, PA

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Records Release

Date___/____/_____

Patient Name_____ DOB___/___/__

Social Security #_____-_____-_____

Records Requested From:_____

_____

I, _____ hereby authorize the release of all medical records (to include office notes, radiological studies, and pathology) in your possession, concerning my illness and/or treatment during the period of:

From_____ To_____

to Andrew J. Shapiro, MD to the above fax or address.

Patient Signature_____ Date_____

Witness Signature:_____ Date_____