

# *Bernard D. Raxlen MD*

566 Fashion Avenue, suite 502  
Manhattan, NY-10018

Phone: 212-799-1121  
Fax: 516-336-8440

## Consent for Release of Information

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

I the above named person, authorize Dr. Bernard D. Raxlen, to receive

My Healthcare Records from:

Name of Physician or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **This request and authorization applies to:**

Most recent labs, diagnostic and radiological results

All health care records

Other

**Name of or Legal Representative:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_