Columbia Presbyterian Eastside Radiology
16 E. 60th Street
New York, New York 10022

MEDICAL RECORD RELEASE
~FILM & REPORT~

I hereby authorize Columbia Presbyterian Eastside Radiology to release medical records as detailed below. The facility, its employees, officers and staff are released from legal responsibility or liability related to the release of this information to the extent indicated and authorized herein.

Patient Name: _____

Date of Birth: _____/_____/_____

Patient Address: _____
Address

_____
City State Zip

Patient Phone #: (_____)_____ Unit #:_____

Information Requested:

Date of Service: _____/_____/_____Study Type: _____

Information to be released to:

_____
Name

_____
Address City State Zip

(_____)_____ ☐ *CHECK HERE IF SAME AS ABOVE.*
Phone

We will not be responsible for sending the requested records if *any* of the above information is missing or incorrect.

►

_____/_____/_____
Signature of Patient or personal representative Date

_____
If personal representative, authority to act on behalf of patient