# RECORDS RELEASE AUTHORIZATION

To _____
Doctor or Hospital

_____
Address

I hereby authorize and request you to release to:

**PARK EAST GYNECOLOGY & SURGERY**
**DR. TAMER SECKIN**
**872 5TH AVENUE**
**NEW YORK, NY 10065**
**212-988-1444**

The complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____

Name _____ Date _____

Address _____

Signature _____ Witness _____
(If relative, state relationship)