BellaDonnaMedical PC
6410 VETERANS AVENUE, SUITE 103
BROOKLYN, NY 11234
(718) 209-6400
F. (718)-209-6060

MEDICAL RECORDS RELEASE

I, _____, hereby request and authorize that the below listed doctor/institution release my individual identifiable health information (IHI) to **Dr Shawn I. Yunayev/BellaDonna Medical PC, 6410 Veterans Avenue, Suite 103, Brooklyn NY 11234-5605**

_____

(DOCTOR'S/INSTITUTION NAME TO RELEASE INFORMATION)

ADDRESS_____

_____

I am aware that I am responsible to pay seventy five cents (.75) per page.

Patients Signature:_____Date:_____

IF PATIENT IS A MINOR OR UNABLE TO SIGN FOR SELF, PARENT/GUARDIAN/REPRESENTATIVE:

Print Name:_____

Signature:_____

Relationship to Patient: _____

Witness Signature:_____Date:_____