



**Langone Medical Center**  
Trinity Center

Medical Records Request

Name \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby request \_\_\_\_\_ to release my medical records

**From:**

\_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SEND TO:**

Attn: \_\_\_\_\_ Trinity Physician: \_\_\_\_\_

NYU Trinity Center  
111 Broadway, 2<sup>nd</sup> Floor  
New York, NY 10006  
Phone: (212)-263-9700  
Fax: (212)-263-9701

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Personal Representative

\_\_\_\_\_  
Relationship to Patient