



at Trinity Center

Medical Records Release

Name _____
Last First Middle

Home Address _____

Telephone _____

Date of Birth _____

I hereby request NYU Medical at Trinity Center release my medical records to:

** Please specify the date of service and records/reports you are requesting. Fax/Mail back this signed form to:*

**NYU Medical at Trinity Center
111 Broadway, 2nd 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