

**Medical Records Request**

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

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

Telephone \_\_\_\_\_

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

I hereby request my medical records be released to:

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

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

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

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship