RECORDS RELEASE AUTHORIZATION

To _____

(Physician or Medical Laboratory/Diagnostic Professionals)

(Address)

I hereby authorize and request you to release to:

NEW YORK GYNECOLOGY ENDOMETRIOSIS (NYGE)

Dr. Pankaj Singhal

375 E. Main Street, Suite 7, Bay Shore, NY 11706

(631) 533–9733

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

Name: _____ Date: _____

Address: _____

Signature: _____ Witness: _____

(Patient or legally authorized individual)