RECORDS RELEASE AUTHORIZATION

TO: _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

ISMAIL OZCAN, M.D.
122 PORTION ROAD
LAKE RONKONKOMA, NY 11779
Tel: (631) 588-6665
Fax: (631) 580-5543

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS and/or TREATMENT DURING THE PERIOD FROM_____TO PRESENT.

NAME _____Date of Birth: _____

ADDRESS_____

SIGNATURE: _____DATE_____