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Director, INN

Endovascular Surgery
Yasunari Niimi, M.D.
Patricia Burrows, M.D.
Rafael Ortiz, M.D.

Vascular Neurosurgery

Vascular Neurology
Carolyn Brockington, M.D.
Mark Kupersmith, M.D.
Pediatric Neurology
Walter Molofsky, M.D.

Pediatric Neurosurgery
Saadi Ghatan, M.D.
Peter Rappa, MBA
Administrator

DATE: _____

I hereby authorize and request you release a copy of my medical records (including images if applicable) in your possession, concerning my illness and treatment during the following period:

FROM: _____ TO: _____

Please send my records to the following address:

For requests of medical images please fill out the following

I am requesting the following study on CD be sent to the address I provided:

I acknowledge that there is a fee of \$20 made payable to: Alejandro Berenstein

Payment would be mailed to the following address:

Roosevelt Hospital
1000 Tenth Avenue
10G – INN
New York, NY 10019
Attn: P.Wong

I have received information regarding my rights under HIPAA (NOTICE OF PRIVACY PRACTICES) and have sent along with this request or have on record a signature acknowledgement.

Sincerely,

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

SIGNATURE: _____