RECORDS RELEASE AUTHORITY

TO: _____

_____

I, _____ hereby request that
Patient's Name

you release to:

NOREEN H. LINN, M.D.
222 Westchester Avenue, Suite 205
White Plains, New York 10604
Telephone: (914) 949-9882

a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____ to _____.

_____ Patient's Date of Birth

_____ Signature of Patient, Parent, Guardian, or Personal Representative

_____ Witness

_____ Please print name signed above

_____ Date

_____ Relationship to Patient

#13109 — Medical Arts Press 1-800-328-2179