



I, Name (please print) _____ D.O.B _____ authorize:
Physician/Facility Name _____
Address _____
Phone _____ Fax _____

To release the pertinent **OB/GYN** history records in your possession, such as office notes, mammograms, sonograms, bone density tests, bloodwork, pathology/cytology, or any pertinent operative procedure notes, concerning my care and treatment during the period of _____ to _____

TO:
Kristen J. Kratzert, MD
Chantell E. Dalpe, MD
Melissa A. Weinstein, DO
MaryLou D'Amico, NPWHC at

The Women's Wellness Place
739 Irving Ave. Suite 300
Syracuse, NY 13210
Phone: 315-478-1158 Fax: 315-478-3014

I understand that this authorization to release information will expire one year from the date of my signature on this form and that I may revoke my authorization at any time in writing before the date of expiration. I may request a copy of this form.

Patient/Guardian signature _____ Date _____
Witness _____ Date _____



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