LILIYA GERSHENGOREN M.D.

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Request / Authorization to Release Confidential Records and Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my protected health information to and from the following doctors/entities:

1. Liliya Gershengoren, MD
   244 Madison Ave #1160
   New York NY 10016
   Tel: 908-840-8814

2. Person or facility: _____
   Address: _____
   Tel: _____ Fax: _____

3. Person or facility: _____
   Address: _____
   Tel: _____ Fax: _____

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Other _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will be considered valid for the duration of your treatment, until revoked in writing.

_____ _____

Patient / Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name Relationship to Patient