Twin Forks Gastroenterology& Hepatology, P.C.

Eyad M. Ali, M.D.

RECORDS RELEASE AUTHORIZATION

TO:_____
(Doctor or Hospital)

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO :

TWIN FORKS GASTROENTEROLOGY AND HEPATOLOGY, P.C.
EYAD M. ALI, MD
332 WEST MONTAUK HIGHWAY, SUITE 1
HAMPTON BAYS, NY 11946
Fax #631-723-0003

THE COMPLETE RECORDS CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM_____ TO _____.

DATE_____

NAME_____

ADDRESS_____

SIGNATURE: _____
(If Relative, State Relationship)

WITNESS: _____

Verbal permission given by patient_____

Staff Signature _____

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Hampton Bays, NY 11946
Phone 631 723 0600
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