RECORDS RELEASE AUTHORIZATION

To:____
DOCTOR OR HOSPITAL

____
ADDRESS

I hereby authorize and request you to release to:

Norman Turowsky, M.D., P.C.
3601 Hempstead Turnpike
Suite 121
Levittown, New York 11756
Telephone 516-520-2900 Fax 516-520-1999

The complete history and records in your possession, concerning my illness and/or treatment

during the period from ______________ to ________________.

Name____Date__________

Address____

Signature______________________________________Witness________________