

Somerset Surgical Associates, P.C.
475 East 72 Street
New York, NY 10021

Date: _____ Time: _____

I _____ consent to have my medical records transmitted to my health, disability or life insurance carriers and to other physicians or health care professionals involved in my care, by mail, e-mail or fax. I consent to representatives of Somerset Surgical Associates, P.C. leaving messages that a telephone communication was attempted, on my answering machine, with my answering service or on my voice mail.

I would like my records sent to:

PHYSICIAN'S NAME _____

ADDRESS _____

PHYSICIAN'S NAME _____

ADDRESS _____

PHYSICIAN'S NAME _____

ADDRESS _____

Details of my medical condition can be shared with the following non-medical persons:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Witness

Patient's Signature

Witness

Patient's Representative's Signature

Relationship_____