COLUMBIA UNIVERSITY
MEDICAL CENTER

David D. Markowitz, M. D.
Associate Clinical Professor of Medicine
Herbert Irving Pavilion
161 Ft. Washington Ave., Suite 853
New York, NY 10032
T (212) 305 – 1024
F (212) 305 – 1039

Authorization For Release of Medical Records

Patient Name: ______________________________ DOB____________ SS#__________________

I, ______________________________ would like copies of **all** my medical records and radiology

reports/cd's from____ to:
(Name of MD or Institution and Dates of Service)

David D. Markowitz, MD
Columbia University Medical Center
Herbert Irving Pavilion
161 Fort Washington Avenue
Suite 853
New York, NY 10032

Please accept my signature as authorization to send my medical records to the above listed address.

Thank you,

______________________________ ____________________
Signature of Patient Date

□ STAT – Patient is being referred for surgery. Please fax records to (212) 305-1039