MEDICAL RECORDS REQUEST

Andrew D. Pearle, MD

I, patient _____ , date-of-birth _____ , am requesting a copy of my medical records from the practice of Andrew D. Pearle, MD.

I would like my records:

☐ Mailed to the following address _____

_____

_____

☐ Faxed to the following number (_____)_____

Please include the following:

☐ Office Note(s)

☐ Operative Report(s)

☐ Radiology Report(s)

☐ Other _____.

Please note: This DOES NOT radiology images, all radiology images (X-ray, MRI, CT, Ultrasound, etc) must be obtained through the **HSS Radiology Record Room** at **(212) 606-1135**.

*****Record requests typically take 5-10 business days.**

_____ _____

Patient Signature Date

_____ _____

Parent Signature (if patient is a minor) Date

This form may be faxed **(212) 774-2798** or mailed to **Andrew Pearle, MD, 535 E. 70th Street, NY NY 10021**