The Westchester Medical Group
Center For Heart and Health
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Please print legibly. Date:_____

Sex: Male ( ) Female ( ) Age:_____

Patient:_____

Patient Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email:_____

Birthdate:_____ Social Security #:_____

Driver's License #:_____

Employer:_____ Position:_____

Employer's address:_____

City:_____ State:_____ Zip Code:_____

Work phone: (_____)_____

Important:

In an emergency notify:_____ **Phone:** (_____)_____

Relationship:_____

Patient authorization:

I hereby authorize Westchester Medical Group Center for Heart and Health to release and forward medical records directly related to this date of service to patient address noted above.

Signed:_____ **Date:**_____