BENJAMIN SPINGARN ROTTENBERG
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INCOMING RECORDS RELEASE FORM

Please type or print clearly!

Patient Name	Date of Birth	Patient's Physician

To (your current provider) _____

I hereby authorize you to release to ___The Offices of Drs. Benjamin, Spingarn and Rottenberg_____

any information including the diagnosis and records of any treatment or examination rendered to my child during the period:

from (date) _____, (year) _____ to (date) _____, (year) ____

_____ _____
SIGNATURE DATE

_____ _____
PRINTED NAME YOUR ADDRESS

9/17/2012