

# *Albany Obstetrics and Gynecology, P.C.*

*319 S. Manning Blvd Suite 201*

*Albany, NY 12208*

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*Debbie Hirt, NP*

TO: Dr. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I, \_\_\_\_\_, authorize you to release my medical records to:

**Albany Obstetrics and Gynecology, P.C.**

**Mercy Care Building Suite 201**

**319 S. Manning Blvd.**

**Albany, N.Y. 12208**

**This release expires 90 days from the date listed below.**

**Date of Request: \_\_\_\_\_**

**Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_**

**Patient's Signature: \_\_\_\_\_**

**Patient's Address: \_\_\_\_\_**

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