Ricki Pollycove, MD

Gynecology * Menopause * Women's Wellness * Infertility * Breast Health * Integrative Medicine

Medical Records Release

Date:_____

To: _____

_____

*NOTE: If more than 15 pgs please do NOT fax!!

I hereby request and authorize the release of copies of my medical records to be sent to Ricki Pollycove, M.D.

____ Complete record

____ Ultrasound results

____ Operative reports

____Pap Smear results

____ Mammogram results

____Lab results

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

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