Jana Colton, MD
(646) 783-0800

Authorization for Release of Information

Patient's Name:_____

I hereby authorize Dr. Colton, MD to contact and obtain and/or provide my medical history and other related information from/to the following people:

Name:	Telephone:
_____	_____
_____	_____
_____	_____
_____	_____

I understand that this correspondence may involve a conversation or a transfer of written material, and that I have the right to revoke the above authorization at any time.

Signature:_____

Printed Name:_____

Date:_____