

Northern Westchester Plastic Surgery, PC  
83 S. Bedford Rd.  
Mount Kisco, NY 10549  
(914) 666-6609

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Patient** Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby request and authorize Northern Westchester Plastic Surgery and/or Malik Kutty, MD to release healthcare information pertaining to the patient named above to:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

OR, fax number \_\_\_\_\_

Patient Signature\* \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to patient (if signature is not that of patient) \_\_\_\_\_

\* If patient is a child, then PARENT or LEGAL GUARDIAN must sign. If legal guardian, then this request MUST be accompanied by proof of legal guardianship prior to release of records.

**FAX this form to (914) 206-4450**