Maternal Fetal Medicine Associates, PLLC
Carnegie Hill Imaging For Women, PLLC
70 East 90th Street
New York, NY 10128
Phone: 212-722-7409
Fax: 212-722-7185

Genetic Counseling
Medical Record Release Form

Date:_____

Physician Name: _____

Address: _____

City, State, Zip: _____

Fax Number: _____

Dear Doctor:

I have an appointment for genetic counseling on (mm/dd/yr) _____.

Please fax my testing records to Maternal Fetal Medicine Associates, PLLC, Attention: GENETICS at 212-722-7185 in advance of my appointment.

Thank you.

Patient Name (Print Clearly): _____

Patient Signature: _____

Patient Birthdate: _____

Patient SS Number: _____