Charles B. Kahn, M.D., F.A.C.P., F.A.C.R.
Wayne G. Riskin, M.D., F.A.C.P., F.A.C.R.
Yesenia Santiago-Casas, M.D., F.A.C.P., F.A.C.R.
Linnette Lopez, M.D., F.A.C.R.
Lynette Nicholson, M.M.S., PA-C

Records Release

Date: ___/___/_______

To: ___________________________________

____

____

By signature below I hereby authorize the release of my records to:

________ Charles B. Kahn, M.D., F.A.C.P., F.A.C.R
________ Wayne G. Riskin, M.D., F.A.C.P., F.A.C.R
________ Dr. Yesenia Santiago-Casas, M.D., F.A.C.P., F.A.C.R
________ Dr. Linnette Lopez, M.D., F.A.C.R

Please include any information regarding the diagnosis and treatment rendered to me during the period from: ________________to: ___________________

________________________________ ________________________________
Signature Print Name

Date of Birth: ___/___/_______ Witness_________________________

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