

Ricki Pollycove, MD

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

Medical Records Release

Date: _____

Records to be sent to:

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

___ Complete record

___ Ultrasound results

___ Operative reports

___ Pap Smear results

___ Mammogram results

___ Lab results

Patient Name: _____

Patient Signature: _____

Date of Birth: _____