Wayside Health Associates

**Jay B. Krasner, MD, FACP**
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# Medical Records Request

Date: _____

To: _____

Address: _____

_____

_____

Patient's Full Name: _____ Date of Birth: _____

The above named has designated Jay B. Krasner, MD, FACP, as a treating health care provider and has hereby authorized Wayside Health Associates to use and disclose his/her Protected Health Information. Please forward **all** of his/her Protected Health Information which you have created, received, or maintain, and that of any other health care providers, facilities or entities you may have in your possession, or a complete copy thereof, at your earliest possible convenience, to the address listed above. He/she has been to be provided with the Notice of Privacy Practices from this office and has signed a written acknowledgement to that effect.

cc: S. L. Bell, Esq.