

Maternal Fetal Medicine Associates, PLLC  
Carnegie Hill Imaging For Women, PLLC  
70 East 90<sup>th</sup> 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: \_\_\_\_\_