



TIME WORTH SEEING
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Release of Patient Information Consent Form

The following patient is requesting that their records be sent to TIME WORTH SEEING. Your assistance to this request is appreciated.

Patient: Name _____
Address _____

Date of Birth _____

Releasing Office: Name _____
Address _____

Phone _____
Fax _____

I, _____, authorize _____
(Patient) (Releasing Office)

to release my records to TIME WORTH SEEING.

(Signature) (Date)

**** Please fax patient records to TIME WORTH SEEING at (585) 723-3556**