SHERI SPIRT, M.D.

PSYCHIATRY

16 East 96th Street Unit 1A

NEW YORK, N.Y. 10128

(212) 595-6901

SSDR18@AOL.COM

www.drsherispirt.com

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEREBY AUTHORIZE DR. SHERI SPIRT TO SEND ALL COPIES OF MY MEDICAL RECORDS AND OR NOTES TO MY PRIMARY CARE PHYSICIAN, DR. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AS WELL AS ANY OTHER TREATING PROFESSIONALS INVOLVED IN MY CARE TO HELP AID IN MY TREATMENT.

Patient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness