

JEFFREY EPSTEIN
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Sheeraz Qureshi MD, MBA
Associate Professor, Orthopaedic Surgery
Minimally Invasive Spinal Surgery
Co-director, Spinal Surgery Fellowship
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Spine Center

February 20, 2017

Dear Patient,

I am writing to inform you that on April 1, 2017, I am moving my practice to Hospital for Special Surgery. This is a new and exciting opportunity for me, and I hope that you will continue your care with me at my new location.

Head of Minimally Invasive Spine Surgery at
Hospital for Special Surgery
East River Professional Building
523 East 72nd Street, 9th Floor
New York, NY 10021

Office: (212) 606-1585
Fax: (917) 260-3185

Please be assured that my colleagues at The Spine Hospital at Mount Sinai, and Hospital for Special Surgery, are committed to providing you with excellent care. If you prefer to continue your care at The Spine Hospital at Mount Sinai, please call 212-241-8947. I recommend each of my colleagues highly.

If you wish to continue care at my new practice, please complete the enclosed medical records release form and return to the designated address for processing.

I want to thank you for allowing me to participate in your healthcare and for allowing me to be your physician. I wish you the best of health now and always and hope to see you in my new practice.

Sincerely,

Sheeraz A. Qureshi, MD



PATIENT ACCESS REQUEST FOR MEDICAL INFORMATION

Patient's Name: EPSTEIN JEFFREY E
(Last) (First) (Middle)

DOB: 01/20/1953 Tel. No.: [REDACTED]
Month/Day/Year

Address: 9E 71 STREET NEW YORK NY 10021
(Street) (City) (State) (Zip Code)

Please request/check all that apply:
ACCESS REQUESTED record copy @ \$.75/page

<u>Records</u>	<u>Bill</u>	<u>Date(s) of Service</u>	<u>Document(s)</u>
<input checked="" type="checkbox"/> Entire Designated Record Set	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Inpatient Visit(s)	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> ED Visit(s)	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ambulatory Surgery	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Outpatient Clinic – Manhattan	<input type="checkbox"/>	_____	_____
◦ Orthopaedics	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> FPA Practice/Provider:	<input type="checkbox"/>	_____	_____
_____		_____	_____
_____		_____	_____
<input type="checkbox"/> X-ray Films/Reports	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pathology Slides/Reports	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Other	<input type="checkbox"/>	_____	_____

Please complete other side

103-200 (Rev 11/03) form Qureshi mailing 0217b
DR. SHEERAZ QURESHI MD.