RECORD RELEASE AUTHORIZATION

Please allow 30 days to process this request.

DATE: ______________________

I hereby authorized and request Dr. _______________________,
400 Main Street, P.O. Box 103, Bedminster, NJ 07921 to release my complete medical record to:

Dr. ____________________________

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ADDRESS

____

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PHONE #

****

PATIENT NAME: ______________________________________

ADDRESS: ____

BIRTH DATE: __________________

SIGNATURE: ____

PARENT/GUARDIAN SIGNATURE: _______________________

RELATIONSHIP: ______________________________________

WITNESS: ____

FAX BACK TO 908-781-7505