RECORDS RELEASE AUTHORIZATION

To: ____________________________________

____

I, ____, hereby request that you release to:

Valley Diagnostic Medical Center
470 N Franklin Tpk, Suite 203
Ramsey, NJ 07446
201-327-0500 tel
201-327-8612 fax

A report of my diagnosis, treatment, prognosis, recommendations, immunization records, as well as other pertinent data to your treatment of me from ___________________ to present.

Date of request: __________________

Patient Signature: ______________________

Parent/Guardian Signature (if patient is a minor): ________________________________

Patient date of birth: ______________