

RECORDS RELEASE AUTHORIZATION

To: _____

I, _____, hereby request that you release to:

Valley Diagnostic Medical Center
581 N Franklin Tpk
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: _____