RECORDS RELEASE AUTHORIZATION

To: _____

Doctor or Hospital

_____

Address

_____ _____

Phone *Fax*

I hereby authorize and request that you release to:

Meetinghouse Family Physicians
105 Evesboro-Medford Road
Suite I
Marlton, NJ 08053

Fax: 856-596-0320
Phone: 856-596-9050

The complete history records in your possession, concerning my illness and/or my treatment during the period:

From these dates: _____ to: _____

Name: _____ Date: _____

Address: _____

_____

Date of birth: _____ Phone Number: _____

SIGNATURE: _____ _____

(if signing for patient, please indicate relationship)

WITNESS (sign): _____ WITNESS (print): _____