RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that:

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

Releases the complete history in possession, concerning my illness and/or my treatment during the stated period to:

_____

Doctor or Hospital

_____

Address

_____ _____

Phone *Fax*

From these dates: _____ to: _____

Name: _____ Date: _____

Address: _____

_____

Date of birth: _____ Contact number: _____

SIGNATURE: _____ _____

(if signing for patient, please indicate relationship)

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