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MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____

DOCTOR OR HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

HOLY NAME PULMONARY ASSOCIATES, PC
8305A BERGENLINE AVENUE
NORTH BERGEN, NEW JERSEY 07047
(201) 845-7200

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____TO _____

NAME: _____ DATE: _____

ADDRESS: _____

SIGNATURE: _____ WITNESS: _____