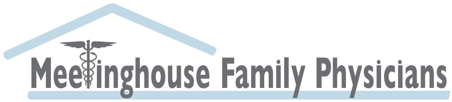

RECORDS RELEASE AUTHORIZATION

To: ____

Doctor or Hospital

____

Address

I hereby authorize and request that you release to:

Meetinghouse Family Physicians
330 E. Greentree Road
Marlton, NJ 08053
Fax: (856) 596-0320

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: __________

SIGNATURE: ________________________ ________________________

(if signing for patient, please indicate relationship)

WITNESS (sign) ____________________ WITNESS (print) ____________________