AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

Date of Request: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____
(Month/Day/Year)

Address: _____

_____

City State Zip Code

Phone Number: _____

I hereby authorize disclosure of my Medical Records:

From: _____

_____

_____

To:

Neepa Merchant MD Family Practice, P.A.
378 South Branch Road, Suite 302
Hillsborough, NJ 08844
Phone: 908-290-0404
Fax: 908-933-0954

_____ _____

Patient's Signature Date