**RECORDS RELEASE AUTHORIZATION**

DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Hematology-Oncology of Central New Jersey, P.A.
180 White Road
Suite 101
Little Silver, NJ 07739
Telephone: 732-530-8666
Fax: 732-530-4139

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD:

FROM _____ TO _____

NAME: _____

ADDRESS: _____

SIGNATURE OF PATIENT DATE

SIGNATURE OF REPRESENTATIVE

RELATIONSHIP OF PATIENT REPRESENTATIVE

WITNESS