510 Hamburg Turnpike, Suite 101, Wayne, NJ 07470
Phone: 973.942.6005 Fax: 973.942.6009

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO ALLIED MEDICAL ASSOCIATES

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

City _____ State: _____ ZIP: _____

I request and authorize the release of healthcare information of the patient named above to Allied Medical Associate by:

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Any information including the diagnosis and records of treatments and examination rendered to the above stated patient while under your medical care. Also release any pertinent medical records that you may have acquired from the patient's previous physician(s) and/or medical care/treatment /diagnostic centers if applicable.

Patient Signature: _____ Date Signed: _____