Allergy Treatment Center of New Jersey, PC

CONFIDENTIAL

MEDICAL RECORD RELEASE AUTHORIZATION

I, _____, hereby authorize and request Allergy Treatment Center of New Jersey, Inc. to release my records to:

PLEASE PRINT

Name of Doctor/Company _____

Address _____

City_____ State_____ Zip_____

Phone _____ Fax _____
0

PATIENT INFORMATION

Name_____

Address_____

City_____ State_____ Zip_____

Phone _____

Signature_____ Date_____

Witness_____ Date_____

The Allergy Treatment Center of New Jersey, Inc. must receive this form with an *original* signature *before* we can release medical records to the authorized person or entity. We cannot accept a fax. While we will do our best to release the records as soon as possible after the receipt of this form, please note that the law permits us 30 days to process this request.

For office use:
Date Records Sent_____ Signature_____

530 Green Street Suite 2 East Iselin, NJ 08830 *fax:* 732.283.3042 *tel:* 732.283.3040
1100 Centennial Avenue Suite 202 Piscataway, NJ 08854 *fax:* 732.562.1770 *tel:* 732.562.1717
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Diplomate, American Board of Allergy and Immunology
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