THE MEDICAL GROUP OF NEW JERSEY
SUSSEX CARDIOLOGY

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RELEASE OF MEDICAL RECORDS

Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

I hereby authorize The Medical Group of New Jersey – Sussex Cardiology to release medical records to:

_____

_____

This includes any diagnostic information and records of treatment or examination rendered to me during the period from _____ to _____

_____ _____
Patient's Signature Date

_____ _____
Print Name Witness