Release of Records

Princeton & Rutgers Neurology, P.A.
A CENTER OF EXCELLENCE

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I, _____, hereby authorize and request that **Princeton & Rutgers Neurology** release any/all medical records concerning my treatment and care

from _____ to _____.

Please release the requested information to the following:

_____
(Name of Doctor or Hospital)

_____
(Street Address)

_____
(City, State, Zip Code)

Phone:_____ **Fax:**_____

Patient Name:_____ **Date of Birth:**_____

Signature:_____ **Today's Date:**_____