FIRST HEALTH
URGENT CARE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient information (please print)

Name ____ Date ________________________

Social Security Number ____

Address ____

City _____________________ State ____________________________ Zip Code _____________________

Phone _____________________________________

Release My Medical Records From:

Name: ___________________________________

Tel: ________________________________

Fax: ________________________________

To:

FIRST HEALTH

152 Central Ave

Clark, NJ 07066

Phone (732) 382-9700

Fax: (732) 382-9707

Please release a copy of all my medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic tests.

By My signature, I Authorize Release of Medical Records

Patient ____ Date ______________________________