Bergen Medical Alliance P A

MDPartners
ENGLEWOOD
HOSPITAL AND MEDICAL CENTER

180 Engle Street
Englewood, NJ 07631

Member of MD Partners of EHMC

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

TO: _____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE AND SEND COPIES OF MY MEDICAL RECORDS TO:

ALICE ABRAHAM, M.D.
GLENN BRAUNTUCH, M.D.
ELAINE CONG, M.D.
DANA CORRIEL, M.D.
MITCHELL ENGLER, M.D.
KATALIN FRISCH, M.D.
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ESTHER LEE, M.D.
ROBERT MALOVANY, M.D.
KILLOL PATEL, M.D.
CLIFFORD SIMON, M.D.
JULIE YIP, M.D.

MAIL RECORDS TO THE ABOVE ADDRESS

THE COMPLETE MEDICAL RECORD IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM _____ TO _____

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

_____ DATE: _____
SIGNATURE OF PATIENT

_____ _____
WITNESS NAME WITNESS SIGNATURE