Medical Records Release Form

By signing this form, I authorize you to release my personal health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ______________________________ Date of Birth:__________________

Information requested:____

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Release information to:

Princeton Wound Care Center
3626 Route 1 North
Princeton, New Jersey, 08540
Phone: 609-945-3611
Fax: 609-945-3688

______________________________	______________________________
Patient Name	Signature of Patient
______________________________	______________________________
Name of Patient Representative	Signature of Patient Representative
______________________________	______________________________
Date	Relationship to Patient