COMPREHENSIVE OB GYN PA
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SARIYE SAVCI, MD
Affiliated with Hackensack University Medical Center

MEDICAL RECORD RELEASE REQUEST

To:_____

(Doctor/Hospital)

Address: _____

(Street)

_____

(City) (State) (Zip)

Phone:_____ Fax: _____

I hereby authorize the release of my _____

(Specific type of records requested or complete medical record)

_____

_____

or copies of such and request that they be transferred to Comprehensive Ob Gyn PA, at the above named location.

Date of Records, From:_____ To: _____

(Month/Year) (Month/Year)

_____

Print Name of Patient Date of Birth

_____

Patient/Guardian Signature Date