DERMATOLOGY ASSOCIATES OF CENTRAL NJ

3548 Route 9 South Suite 2 · Old Bridge, NJ 08857 · Tel.: (732) 679-6300 · Fax: (732) 679-9566

Medical Records Release Request

Date:_____

Patient:_____

Date of Birth:_____

I hereby authorize the release of all my medical record or copies to:

Dermatology Associates of Central New Jersey
3548 Route 9 South Suite 2
Old Bridge, New Jersey 08857
Phone: 732-679-6300
Fax: 732-679-9566

Signature of Patient:_____

Please mail/fax medical records to the above address and or number provided.

Records must be received by:_____

Thank you for your assistance!

Please provide the office we are to request records from:

_____

_____

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