September 9, 2011

David A. Wang, M.D.
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Paramus, NJ 07652
Tel 201-599-8020
Fax 201-599-8022

REQUEST FOR RELEASE OF HEALTH INFORMATION

DATE: _____

TO: _____
Doctor or Hospital

ADDRESS: _____
_____
_____

TEL: _____ *FAX:* _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT TO DR. DAVID A.WANG AT THE ADDRESS OR FAX NUMBER LISTED ABOVE.

Patient Name: _____
Last First MI

Address:

_____
_____
_____
_____

Telephone:

_____ (daytime)
_____ (evening)

Email Address (optional):

_____

Social Security #:

_____

Date of Birth:

_____

SIGNED_____ _____
Patient or Nearest Relative/Relationship Print Name

WITNESS _____