Holistic ObGyn

1700 Route 3; Clifton, NJ 07013;
141 Passaic avenue, Passaic, NJ 07055
973-747-5217; 973-396-8832 FAX

In Reference to: RECORD RELEASE

Date of Request:_______________________________

Name:_______________________________________

Date of Birth:__________________________________

Address:_____________________________________

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Reason for requesting:
[ ] transferring service

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I, ______________________________ hereby request that you release
(your name)

to ________________________________ [ ] myself, all medical

records.

I hereby confirm receiving my medical records.

X____ ________________
Signature Date