RECORDS RELEASE AUTHORIZATION

FROM:

_____

DOCTOR OR HOSPITAL

_____

ADDRESS

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

PETER W. COPPOLA, M.D.
MICHAEL DENKER, M.D.
751 TEANECK RD.
TEANECK, NEW JERSEY 07666
TELEPHONE 201-837-3200
FAX 201-837-8993

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____TO_____

NAME_____DOB _____

ADDRESS_____

PHONE NUMBER _____

SIGNATURE _____WITNESS_____

IF RELATIVE, STATE RELATIONSHIP

DATE _____