Princeton & Rutgers Neurology, P.A.
A CENTER OF EXCELLENCE

Medical Records Release

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800 Bunn Drive Suite 204
Princeton, NJ 08540
T. 609-497-0300
F. 833-914-0455

To:_____
(Name of Doctor or Hospital)

_____
(Street Address)

_____
(City, State, Zip Code)

I, _____, hereby authorize and request that you release all my medical records concerning my illness and/or treatment during the time period of _____ to _____.

Please send my requested medical records to

PRINCETON & RUTGERS NEUROLOGY

☐ 77 Veronica Avenue, Ste 102 Somerset, NJ 08873
P: 732-246-1311 **F**: 833-914-0459

☐ 9 Centre Drive, Suite 130 Monroe, NJ 08831
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Patient Name: _____ **Date of Birth**: _____

Signature: _____ **Today's Date**: _____