Princeton & Rutgers Neurology, P.A.

A CENTER OF EXCELLENCE

Release of Records

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I, ______________________________, hereby authorize and request that **Princeton & Rutgers Neurology** release any/all my medical records concerning treatment and care from ________________ to _________________.

Please release the requested information to the following:

____

(Name of Doctor or Hospital)

____

(Street Address)

____

(City, State, Zip Code)

Phone: ___________________ **Fax**: ___________________________

Patient Name: ___________________________ **Date of Birth**: ________________

Signature: ______________________________ **Today's Date**: ________________