# 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**: ________________