



MEDICAL RECORDS RELEASE FORM

(From another Physician to Immedicenter)

**AN IMMEDIATE
MEDICAL DIAGNOSTIC
AND TREATMENT CENTER**

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PATIENT: _____

ADDRESS: _____

PHONE NUMBER: _____

BUSINESS NUMBER: _____

DATE OF BIRTH: _____ S.S. #: _____

My permission is granted to:

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS: _____

To disclose to:

**IMMEDI CENTER-CLIFTON
1355 BROAD STREET
CLIFTON, NJ 07013
973-778-5566**

Information concerning the medical findings/treatment of this patient.

Circle One: **ALL RECORDS** **ONLY THESE DATES (list below)**

FROM: _____ TO: _____
(Date) (Date)

I release the above named doctor from any laws related to disclosure of confidential and privileged information.

X _____
Signature (Parent/Guardian if patient is a minor) Date

X _____
Witness Date

**1355 Broad Street
Clifton, New Jersey 07013
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