AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected under the federal law. I request and authorize to release healthcare information of the patient named above to:

Dr. Robert Fortino
129 Johnson Road, A3
Blackwood, NJ 08012

This request and authorization applies to healthcare information relating to:

❑ Qualifying condition: _____

❑ All Healthcare Information

Physicians Name: _____

Phone:_____

Fax: _____

Patient Signature:_____ Date Signed: _____

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