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: _____

P: 856.318.4100 F: 856.827.0029
Info@TheGreenAlternativeDoctor.com
www.TheGreenAlternativeDoctor.com