



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