JOY
INTERNAL MEDICINE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

To:_____

Fax number: _____
or
Address: _____

Please send a copy of my medical records, including: office visits, labs, tests, imaging, ekg, for the last ____ year(s) to:

JOY Internal Medicine
Fax: 201-585-0902
or mail to above address.

Name of Patient: _____ Date of Birth: _____

I attest that I have a legal right to these medical records as either the patient or the legal guardian/parent.

SIGNATURE: _____ DATE: _____