

THE NEUROSCIENCE CENTER OF NORTHERN NEW JERSEY, P.A.

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RECORDS RELEASE AUTHORIZATION

TO _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

- MARK S. DIAMOND, M.D.
- STUART W. FOX, M.D.
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THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____
(IF RELATIVE, STATE RELATIONSHIP)