

New Providence Internal Medicine Associates

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Paul B. Zukoff, MD, FACP
James J. Hakim, MD, FACP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME OF PATIENT: _____

DATE OF BIRTH: _____

STREET: _____

CITY, STATE, ZIP: _____

PHONE: _____

I request and authorize the release of the medical record of the above individual:

from _____
Name of doctor/practice
 to _____
Street

City, State, Zip

from New Providence Internal Medicine Associates
Paul B. Zukoff, MD, FACP
 to James J. Hakim, MD
1252 Springfield Ave.
New Providence, NJ 07974

During the period of _____ to _____.

This information may include, unless crossed out by me:

- substance abuse information, information about AIDS and HIV, history and physical examination, consultations, diagnostic testing, psychiatric illness, psychosocial history, treatment recommendations.
- other: _____ .

Signature of patient (or legal representative)

Date