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Victor Gorloff, M.D., F.C.C.P.*
Paul S. Han, M.D., F.C.C.P. * ↑
Harris B. Tesher, M.D.

200 Grand Avenue, Suite 102
Englewood, New Jersey 07631
Tel: (201) 871-3636
Fax (201) 871-2286

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: ____
DOCTOR OR HOSPITAL

____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

HOLY NAME PULMONARY ASSOCIATES, PC
200 GRAND AVENUE SUITE 102
ENGLEWOOD, NEW JERSEY 07631
(201) 871-3636

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM ____________________TO ____________________

NAME: ____ DATE: ________________

ADDRESS: ____

SIGNATURE: _____________________________ WITNESS: ___________________________