Date: _____

To: _____

RE: Release of Medical Records

Patient Name: _____

DOB: _____ SSN: _____

To Whom It May Concern:

I hereby authorize release of medical information to Dr. Marc Mandel. This information will be used to further assist in my medical care, and should be mailed or fax to:

Marc Mandel, M.D., F.A.C.S.
11 Overlook Road, Suite 160
Summit, NJ 07901
Fax: 908-598-0298

Your prompt response to this request will be greatly appreciated.

_____
Signature of Patient