DEPARTMENT OF HEALTH AND SENIOR SERVICES
CONSUMER AND ENVIRONMENTAL HEALTH SERVICES
PO BOX 369
TRENTON, N.J. 08625-0369
www.nj.gov/health

MEDICAL RECORDS RELEASE FORM

Patient's Name: _____

Address: _____

Date of Birth: _____

I hereby authorize _____

Physician's name

_____
Physician's phone number

_____
Physician's fax number (if known)

_____
Physician's address (if known)

to release my medical records via MAIL/FAX to the New Jersey Department of Health and Senior Services Division of Epidemiology, Environmental, and Occupational Health PO Box 369 Trenton, NJ 08625-0369

FAX: (609) 588-2516
PHONE: (609) 588-8536
ATTN: _Mary T. Glenshaw, PhD, MPH _____

Signed: _____ Date:_____

Relationship:_____