BRANCHBURG EYE PHYSICIAN'S, P.A.
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Office (908) 526-5424
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RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Patient DOB: _____

Patient Address: _____

_____

Patient Phone Number: _____

I request and authorize Branchburg Eye Physician's to disclose the requested information to:

_____
Physician's Name

_____
Physician's Address

_____ _____
Patient's Signature Date