

RECORDS RELEASE / REQUEST

To: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I hereby authorize the release of my _____

or copies of such, and request that they be transferred to:

**BREAST CARE & TREATMENT CENTER
200 SOUTH ORANGE AVENUE
LIVINGSTON, NJ 07039
PHONE: (973) 533 - 0222
FAX: (973) 535 - 1121**

Print Name of Patient: _____

Records dated From : _____ **To:** _____

Patient Signature: _____ **Date:** _____