RECORDS RELEASE/REQUEST

TO: _____ (Doctor/Facility)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I hereby authorize the release of my medical records and request that they be transferred to:

THE MINNITI CENTER

Medical Oncology & Hematology

174 Democrat Rd.

Mickleton, NJ 08056

(856) 423-0754 Fax: (856) 423-7508

PATIENT: _____ DOB: _____

FROM: _____ TO _____

PATIENT SIGNATURE: _____

DATE: _____