

I

_____, hereby authorize
and request _____
to release to Rutgers Cancer Institute of New Jersey, information from the medical
record of: _____

Patient Name: _____ Date of Birth (mm/yy): _____

Please select all that apply:

- Face Sheet Discharge Summary Progress Note(s)
 Diagnostic Report(s) History and Physical Operative Report(s)
 Pathology Report(s) Pathology Slides
 Other: _____

This authorization shall be in effect for sixty (60) days following the date of signature, and includes permission to release information related to the treatment of any psychiatric problems, drug abuse, alcoholism, AIDS, or tests for infection with the human immunodeficiency virus (HIV).

Signature of Patient or Representative Date

Print Name Relationship to Patient (*if Representative*)

Please send records as follows:

Mail to:

Rutgers Cancer Institute of New Jersey
195 Little Albany Street
New Brunswick, NJ 08903

Attn: _____

Fax to:

732-235-8099 (*Medical Records Department*)
Or
732-235- _____

Attn: _____