

# RECORDS RELEASE AUTHORIZATION

TO \_\_\_\_\_

DOCTOR OR HOSPITAL

\_\_\_\_\_

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

BRIAN A. COLE, M.D.

ENGLEWOOD SPINE ASSOCIATES, LLC

300 GRAND AVE., SUITE 201

ENGLEWOOD, NJ 07631

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING

THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_

(IF RELATIVE, STATE RELATIONSHIP)