AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____

RELEASE TO:

Name: Andrew Medvedovsky, MD New Jersey Alternative Medicine

Address: 151 Fries Mill RD, Suite 104, Turnersville, NJ 08012

Phone: 856-302-0855 **Fax:** 856-827-0034

Purpose for release: Communication of purpose____**x**_____

Information to be released: QUALIFYING CONDITION_____

PHYSICIAN NAME: _____

PHONE: _____ **FAX:** _____

I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected under the federal law.

Signature: _____ **Date:** _____