JFK Medical Associates

RARITAN BAY CARDIOLOGY GROUP
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Medical Records Consent

Physician Name: _____

Physician Address: _____

Patient Name: _____ Date: _____

Address: _____

SS#: _____

I hereby give consent for _____ to obtain my medical record from any medical
Physician's name(s)
facility for the purpose of review by above physician to coordinate my medical care.

Complete Medical Records: _____

Other (specify): _____

_____ _____
Patient Signature Date