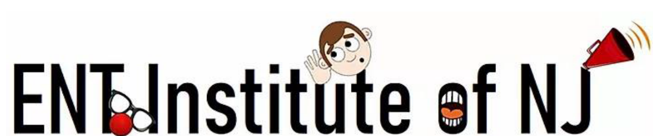

P Don S. Respler M.D., F.A.C.S.
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Hackensack, NJ 07601
NPI: 1073581740 TIN: 22-3080365

Phone: 201- 996-9200
FAX: 201-996-9277
AngelsofENT@gmail.com

RELEASE OF PATIENT'S RECORDS FORM

NAME OF PATIENT: ____

DATE OF BIRTH: ____

ADDRESS: ____

____

____

____

I hereby authorize Dr. Don Respler to release records of the above-mentioned patient to the following person:

____

( ) via mail

ADDRESS: ____

____

____

____

( ) via FAX
FAX NUMBER: ________________________ ATTENTION: _______________________

( ) via EMAIL
EMAIL ADDRESS _____________________ ATTENTION: ________________________

( ) Clinical records from last two (2) years (free of charge)

( ) Billing records from last two (2) years (free of charge)

( ) All clinical records ($35 fee must be submitted with this form)

( ) All billing records ($15 fee must be submitted with this form)

NAME: ____

LEGAL RELATIONSHIP TO PATIENT: ____

SIGNATURE: ____

DATE: ____________________________________ FEE ENCLOSED: $_______________