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TRANSFER OF MEDICAL RECORDS

IF YOU WISH TO HAVE YOUR MEDICAL RECORDS TRANSFERRED TO OUR OFFICE FROM ANOTHER PHYSICIAN, PLEASE FILL OUT AND RETURN THIS FORM TO US VIA FAX OR MAIL.

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: / /

SOCIAL SECURITY NUMBER: XXX - XX -

I HEREBY AUTHORIZE DR. _____TO RELEASE MEDICAL RECORDS FOR THE ABOVE-NAMED PATIENT TO:

PHYSICAN NAME: **RONALD SACHS, M.D.**

ADDRESS: **8 SADDLE ROAD STE 201 CEDAR KNOLLS, N.J. 07927**

AUTHORIZATION: _____DATE: _____
