RECORDS RELEASE

Date__________________________

Patient's Name__________________________________ DOB____________________________

I hereby authorize you to release to:

Cardiology Associates of Sussex County, LLP
222 High Street, Suite 205
Newton, N.J. 07860

Please include the diagnosis and records of any treatment or examination rendered to me during the period from__________________________to__________________________.

____ ________________________________
Patient's Signature Date

____ ________________________________
Witness Signature Date

A.casc11