Date: ___________________

Patient's Name: ____

Patient's Date of Birth: __________________________________

To Facility Information / Doctor Name: ____

____

Phone: _____________________________ Fax Number: ______________________________

I hereby authorize you to release records to:

Cardiology Associates of Sussex County, LLP
222 High Street, Suite 205
Newton, NJ 07860
Phone: (973)579-2100 || Fax: (973)579-6638

Please include any diagnostic testing and medical records of any treatments or examinations during the period from _____________________________ to ___________________________

____ ______________________________

Patient Signature Date

____ ______________________________

Print Name Witness

Richard C. Redline, MD, FACP, FACC
Robert L. Masci, MD, FACC
David S. Buyer, MD, FACC
Gerald Cioce, MD, FACC, FSCAI
Scott A. Schwarz, MD, FACP, FACC
Benjamin R. Bergman, MD, FACC
Thomas A. Lanzilotti, MD, FACC
Maria L. Bazsa, APN-C
Linda Tabor, APN

222 High Street, Suite 205, Newton, NJ 07860
Phone: (973)579-2100 || Fax: (973)579-6638

111 East Catharine Street, Suite 220, Milford, PA 18337
Phone: (570)296-4500

5 Route 94, Building F, Vernon, NJ 07462
(973)827-0844

www.sussexheart.com