THE MEDICAL GROUP OF NEW JERSEY
SUSSEX CARDIOLOGY

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:

The Medical Group of New Jersey – Sussex Cardiology
222 High Street, Suite 205
Newton, NJ 07860
Phone: (973)579-2100 || Fax: (908) 552-7913

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

_____ _____
Patient Signature Date

_____ _____
Print Name Witness

Robert L. Masci, MD, FACC
Gerald Cioce, MD, FACC, FSCAI
Scott A. Schwarz, MD, FACP, FACC
Benjamin R. Bergman, MD, FACC
Conner O'Keefe, MD, RPVI
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111 East Catharine Street, Suite 220, Milford, PA 18337
Phone: (570)296-4500

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www.sussexheart.com