Northern Valley Allergy
Asthma & Sinus Center

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136 N. Washington Ave.
Suite 203
Bergenfield, NJ 07621

8901 John F. Kennedy Blvd. W.
Suite 4SW
North Bergen, NJ 07047

Medical Release Form

Patient Name: _____
Patient DOB: _____
Date: _____

I hereby give this facility permission to release all of my medical records (consults, labs, etc.) to Northern Valley Allergy, Asthma and Sinus center. Please fax my records to 201-374-1719. If you have any questions or concerns please do not hesitate to contact our office with any questions or concerns.

_____ _____
Patient/Guardian signature Date

_____ _____
Print Patient/Guardian Name Date

_____ _____
Relationship to patient Date