RECORDS RELEASE

DATE: _____

TO: _____

I hereby authorize you to release to:

Raymond Pekala MD
215 White Horse Pike
Haddon Heights, NJ 08035
Phone: 856-547-1646
Fax: 856-547-9138

Any information including the diagnosis and records of any treatment or examination rendered to me.

_____
Date

_____
Signature

_____
Address

_____
City, State, Zip