THE HEART CENTER OF THE ORANGES

RECORDS TRANSFER REQUEST

Date: - _____

To:- _____
(DOCTOR/HOSPITAL)

ADDRESS: - _____

CITY: - _____ STATE: - _____ ZIP: - _____

DOB:- _____

I HEREBY AUTHORIZE THE RELEASE OF MY _____
OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

REQUESTING DOCTOR :- _____

PHONE :- _____ _____ FAX:- _____

☐ THE HEART CENER OF THE ORANGES
310 CENTRAL AVE, SUITE
EAST ORANGE, NJ 07019

☐ THE HEART CENER OF THE ORANGES
95 MAIN STREET
WEST ORANGE, NJ 07052

☐ THE HEART CENER OF THE ORANGES
92 OLD NORTHFIELD ROAD
WEST ORANGE, NJ 07052

☐ THE HEART CENER OF THE ORANGES
77 MAIN ST
WEST ORANGE, NJ 07052

☐ THE HEART CENER OF THE ORANGES
60 VOSE AVE
SOUTH ORANGE, NJ 07040

☐ THE HEART CENER OF THE ORANGES
2091 MILLBURN AVE, SUITE # 401
MAPLEWOOD, NJ 07040

_____ _____

PRINT NAME OF PATIENT **SIGNATURE (PATIENTS, PARENT OR GUARDIAN)**