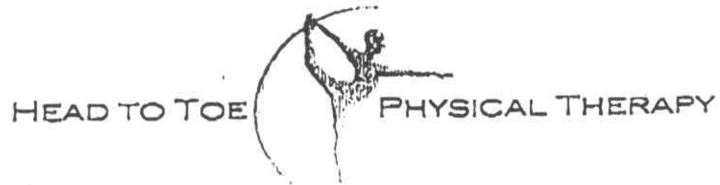

SOUTH ORANGE REHABILITATION & WELLNESS

PATIENT REQUEST FOR RECORDS

To: ____
(Doctor or Hospital)

Address: ____

City: ____________________ State: ______________ Zip: ____________

I hereby authorize and consent to the release of my medical records including radiographic films or copies of such and request they be transferred to:

South Orange Rehabilitation & Wellness
177 Valley Street
South Orange, NJ 07079

____
Print Name of Patient   Patient Social Security Number

____
Patient Date of Birth

____
Date of Records

____
Patient Signature   Date

SOUTHORANGEREHAB.COM
177 VALLEY STREET
SOUTH ORANGE, NJ 07079
T-973-761-0077
F-973-761-0024