REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and request _____
Name of doctor with old records

_____
Street address of doctor or hospital above

_____
City State Zip

To release my medical records to:

Summit Internal Medicine, LLC
Lisa H. Toffey, M.D.
Emily L. Jeffries, M.D.
Gomathy Subramanian,M.D.
Gillian McKie, R.N.., APN-C
33 Overlook Road Suite L06
Summit, New Jersey 07901
(908) 522-0050

I _____give Dr. _____

Permission to speak with _____about my medical condition.

_____ _____
Print your name Birthday

_____ _____
Signature Date