RUTGERS
Cancer Institute
of New Jersey

Release of Medical Records

I _____, hereby authorize and request _____ to release to Rutgers Cancer Institute of New Jersey, information from the medical record of: _____

Patient Name: _____ Date of Birth (mm/yy): _____

Please select all that apply:

- ❑ Face Sheet
- ❑ Discharge Summary
- ❑ Progress Note(s)
- ❑ Diagnostic Report(s)
- ❑ History and Physical
- ❑ Operative Report(s)
- ❑ Pathology Report(s)
- ❑ Pathology Slides
- ❑ Other: _____

This authorization shall be in effect for sixty (60) days following the date of signature, and includes permission to release information related to the treatment of any psychiatric problems, drug abuse, alcoholism, AIDS, or tests for infection with the human immunodeficiency virus (HIV).

_____ Signature of Patient or Representative

_____ Date

_____ Print Name

_____ Relationship to Patient *(if Representative)*

Please send records as follows:

Mail to:

Rutgers Cancer Institute of New Jersey
195 Little Albany Street
New Brunswick, NJ 08903
Attn: _____

Fax to:

732-235-8099 *(Medical Records Department)*
Or
732-235- _____
Attn: _____

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Rutgers, The State University of New Jersey
195 Little Albany Street ▪ New Brunswick, NJ 08903-2681
Phone: 732.235.CINJ (2465) ▪ cinj.org