

THE GASTROENTEROLOGY GROUP OF NORTHERN NEW JERSEY, LLC

ENGLEWOOD DIVISION

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ENGLEWOOD CLIFFS DIVISION

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Eugene S. Han, M.D.

Please complete the following information:

Physician's name: _____

Address: _____

_____ Phone #: _____ Fax # _____

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ Date of Birth: _____

I authorize the custodian of records of to release the following information (check all applicable):

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Abstract/Summary |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Pharmacy/Prescription records |
| <input type="checkbox"/> X-ray/radiology records | <input type="checkbox"/> Other (describe specifically) _____ |

Dates for services provided on the following dates: _____

This information should be sent to the following:

The Gastroenterology Group of Northern New Jersey, LLC.
ENGLEWOOD DIVISION
420 Grand Ave. Ste 101
Englewood, NJ 07631
201-569-7044
201-569-1999 FAX

Patient's signature

Date

Printed Name

Witness

Records from another MD to our office