

Summit Ob Gyn LLC  
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Affiliated with Hackensack University Medical Center, St. Joseph's Regional  
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Record Release/Request

To: \_\_\_\_\_  
(Doctor/Hospital)

Street Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

I hereby authorize the release of my \_\_\_\_\_

Or copies of such, and request they be transferred to

Summit Ob Gyn LLC  
331 Summit Ave  
Hackensack, NJ 07601

\_\_\_\_\_  
Print Name of Patient Date of Birth

\_\_\_\_\_  
Patient's Signature Date