Health Department
475 Valley Road
Wayne, New Jersey 07470-3586
www.WayneTownship.com
Phone: 973-694-1800
Fax: 973-696-8186

Release of Medical Records Form

Request to release Medical records of ______________________________ for the time period
Patient's Name
dating from ________ to ___________ from the following Wayne Health Department Clinics:

- ☐ Children's Health Conference (well child clinic)
  - ☐ Immunization records only
- ☐ Dental Clinic
  - ☐ X-rays only
- ☐ Women's Awareness
- ☐ For Men Only
- ☐ Other ______________________________

The Medical Records as listed above are to be released to:

Name: ____

Address: ____
Street City State Zip Code

Phone Number: ___________________________ Fax Number: _____________________________

Comments____

____

____________________________________ ____________________
Print Patient's Name Date of Birth

____________________________________ ____________________
Signature of patient or parent/guardian Today's date

Only the patient or parent/guardian may request a release of medical information.
Picture ID may be required.

Office use only

_______________________ _______________________________________
Date records released Signature of Public Health Nurse