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## RELEASE OF MEDICAL RECORDS

Date: \_\_\_\_\_

To Whom It May Concern:

Please release medical records including \_\_\_\_\_ for the  
following dates: \_\_\_\_\_ to:

Active Orthopaedics and Sports Medicine, PA  
25 Prospect Avenue, 2<sup>nd</sup> Floor  
Hackensack, NJ 07601  
(201)343-2277  
Fax (201)343-7410

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_