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MEDICAL RECORDS RELEASE/REQUEST

Date: ______________________________

Patient Name: ______________________________

D.O.B.: ______________________________

Address: ______________________________

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Signature: ______________________________

I, ______________________________ , hereby authorize Wayne Behavioral Service,
LLC at 401 Hamburg Turnpike, Suite 302, Wayne, New Jersey 07470 to release/request my
circle one complete medical records of any reports, notes, evaluations or histories to/from:

circle one

Name: ______________________________

Address: ______________________________

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Telephone #: ______________________ Fax #: ______________________

Restrictions:

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