TEANECK VOLUNTEER AMBULANCE CORPS
P.O. BOX 32
TEANECK, NJ 07666

MEDICAL RECORDS REQUEST

Date of request: ___/___/____

Name of person requesting records: _____

Preferred contact method: phone: _____ email: _____

If above individual is not the patient, state relationship to patient: _____

Name of patient:_____

Date of call: ___/___/____ Approximate time: ___:___ Location: _____

Mailing information: _____

_____

_____

Please submit request to:
Teaneck Volunteer Ambulance Corps
Attn: Records Officer
P.O. Box 32
Teaneck, NJ 07666
Fax: 201-692-1260

Please allow up to 2 weeks for processing. A nominal processing fee may be requested.

Authorization:
Must be signed by patient or patient's legal guardian

Signature: _____ □ Patient □ Legal Guardian

Notary Acknowledgement:

State of New Jersey, County of _____
On _____, before me, _____, Notary Public, in and for said county, personally appeared _____ who has satisfactorily identified him/herself as the signer to the above document.

Signature: _____ Date:___/___/___ Commission expires: ___/___/___

(Affix seal)