ROBIN ELLEN LEDER, M.D.

General & Nutritional Medicine

235 Prospect Avenue
Hackensack, NJ 07601
Tel. (201) 525-1155

The undersigned patient,_____, requests the release of his/her lab results to :

Name: _____

Address:_____

_____

He/She has elected not to review these results with Dr. Robin Leder in this office prior to their release.

Said patient, _____, has further been advised to review these results fully with a physician as soon as possible, and so further acknowledges by signing his/her name below.

_____ _____
Patient Name (Print) Patient Signature

_____ _____
Date Witness Signature