New Jersey Center for Prostate Cancer & Urology

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I hereby give my permission for the results to be obtained on my behalf, as long as I am a patient of the New Jersey Center for Prostate Cancer and Urology. Please send requested information to the following:

_____ Fax to 201-487-2602

_____ Send to:
New Jersey Center for Prostate Cancer and Urology
255 W. Spring Valley Avenue
Maywood, NJ 07607

X____ _______________________
Sign Name Date

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Print Name