MEDICAL RECORD RELEASE FORM

Authorization for Release of Medical Information

Patient Name_________________________________ DOB__________

Address____

Phone____________________ Email____________________________

TO: ____

Name of Provider/facility

I hereby authorize and request you to send or fax my medical records to Dr.___________________________________ at the address noted below.

731 Alexander Road, Suite 200
Princeton, NJ 08540
Tele: 609-655-3800
Fax: 609-655-5203

TYPE OF RECORDS REQUESTED:

___Complete Medical Record

___Immunization Record

___Records checked below from the past _______ Years

- ___Complete Medical record
- ___Doctors notes/H&Ps
- ___Labs ___ Colo/Endoscopy results
- ___X-ray studies (Mammos, U/S, MRIs, CTs etc)
- ___Medication list
- ___EKG/Stress tests/Echo
- ___Hospital discharge summaries
- ____Other:____

____ Date________________

Patient Signature or legal guardian