Request for Medical Records

REQUEST FOR MEDICAL RECORDS

RE: Release of medical records for ____________________ D.O.B. ______

Provider Name: _________________________________

Medical Practice/Hospital Name: ___________________________________

Street Address of Provider: ____

City, State, Zip code: ____

Phone & Fax #: ____

Dear Provider,

Please release my complete medical records/file to the following provider. This information will be used to further assist in my medical care and should be faxed to:

Atlantic Medical Group Pediatrics at Florham Park
Fax: 973-992-1005

Or mailed to:

Atlantic Medical Group Pediatrics at Florham Park
128 Columbia Turnpike
Florham Park, NJ 07932

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Patient/Parent/Guardian Signature