Medical Record Request - Outgoing

TO:

Windsor Regional Medical Associates, LLC
300A Princeton-Hightstown Road Ste 102
East Windsor, NJ 08520

I _____ hereby request and authorize you to send copies of all of
(Patient's Name)

the chart records checked below (check all that you want sent):

___ progress notes
___ laboratory reports,
___ radiology reports,
___ hospital and operative summaries
___ consultant physician letters

Or

___ all available records

from _____ to _____.
(Date/Month/Year) (Date/Month/Year)

Information to exclude _____.

Reason I want information disclosed (example: changing doctors, disability claim, life insurance application):

_____

Please send this information to:

_____

_____

_____

I understand that a fee of $1 per page, minimum $10 and maximum $100 per request, may be charged to me for these records as established by New Jersey law, and agree to pay any such fees.

_____ _____
Signature of Patient Date

_____ _____
Print Patient Name Patient's Date of Birth

Expiration date of request will be 1 year from today's date or as specified here: _____