Medical Record Request

TO: _____

_____

_____

_____

I _____ hereby request and authorize you to send all documents
(Patient's Name)
relevant to my current medical care, including but not limited to:

laboratory reports,
radiology reports,
hospital and operative summaries, and
consultant physician letters

from _____ to the present. Please also include any records of immunizations administered.
(Date/Month/Year)

Data to exclude and not send includes information readily available to physicians at the University Medical Center at Princeton through the Ultiview computer system (please indicate such information exists),

and _____.

Reason patient wants information disclosed (Example: Physician Referral)

_____

Please send this information to:

Windsor Regional Medical Associates, LLC
300A Princeton-Hightstown Road Ste 102
East Windsor, NJ 08520
(609) 490-0095

_____ _____
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 below.