REQUEST FOR MEDICAL RECORDS

PATIENT REQUEST FOR THE RELEASE OF MEDICAL RECORDS

I, the undersigned Patient (and/or Legal Representative), would like to review following patient records (Specify the patient name and a description of the records requested (including any applicable dates):

Patient Name: _____

Description of records requested: _____

_____

☐ I would like copies of these records. *

☐ I would like copies of my records sent to the following address:

_____

_____

_____

Signature: _____ Print Name: _____ Date: _____

If someone other than the patient requests access to patient records, please describe below the relationship of the requestor to the patient:

_____

_____

_____

In accordance with the New Jersey Administrative Code §13:35G-6.5© (4) there will be a $ 1.00 per page copying fee, plus an extra fee for special mailing requirements. All requests must be sent to the Central Business Office to the attention of Kaitlin McEnery Medical Record Clerk for processing. If you have any questions please call Kaitlin at 631/580-5200.

Site Location: _____