



123 Franklin Corner Road  
Suite 214  
Lawrenceville, NJ 08648  
P: 609-896-1400  
F: 609-896-3986

1401 Whitehorse-Mercerville Road  
Suite 218  
Hamilton, NJ 08619  
P: 609-890-2412  
F: 609-890-2456

909 Floral Vale Blvd.  
Yardley, PA 19067  
P: 215-504-9090  
F: 215-504-9465

## RECORDS RELEASE AUTHORIZATION

Patients Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize and request you to release medical records to:

**Name:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

**Street address:** \_\_\_\_\_

**City, State, and Zip Code** \_\_\_\_\_

I am requesting the complete history of records in your possession, concerning my obstetrical and/or gynecological care during the period from: \_\_\_\_\_ to \_\_\_\_\_

Please mark off the appropriate statements:

- I am transferring out of the practice  
Reason: \_\_\_\_\_
- I am seeking a second opinion
- I am moving and transferring out of the practice
- I need a copy of my records for my primary doctor

Signature: \_\_\_\_\_

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We have received your request dated: \_\_\_\_\_

We will have your records ready to mail or pick up by (10 business days): \_\_\_\_\_