Lawrence
OB/GYN ASSOCIATES

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

1401 Whitehorse-Mercerville Road
Suite 212
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:

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

Signature: _____

We have received your request dated: _____

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