J O S E P H R . R A C C U G L I A , M D
F R E E H O L D O F F I C E P L A Z A
4 2 5 1 U S H I G H W A Y 9 N O R T H
B U I L D I N G 3 , U N I T A
F R E E H O L D , N J 0 7 7 2 8
7 3 2 - 7 8 0 - 3 7 4 4 (T E L E P H O N E)
7 3 2 - 7 8 0 - 9 6 4 4 (F A X)

REQUEST FOR RELEASE OF MEDICAL RECORDS

A request for release of medical records must be signed by the patient or his/her legal guardian, if applicable. Please use a separate form for each patient requesting a record release.

In accordance with NJAC 13:35-6.5, if you would like a copy of your record to be sent to another physician or yourself, copying charges are $1.00 per page with a minimum fee of $10 and a maximum of $100.00, plus $10.00 mailing, (if necessary).

Please print clearly	
PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:
Date of Birth:	Social Security Number:
Address:	City:
State:	Zip Code
Telephone: ( )	

I hereby authorize the release of my medical record(s) to:

____

____

____

Please release: ☐ my entire record
☐ my record for the following range of dates: ______________ to ______________

SIGNATURE OF PATIENT/GUARDIAN (If patient is a minor):	**Date of Request:**