

JOSEPH R. RACCUGLIA, MD

FREEHOLD OFFICE PLAZA
4251 US HIGHWAY 9 NORTH
BUILDING 3, UNIT A
FREEHOLD, NJ 07728
732-780-3744 (TELEPHONE)
732-780-9644 (FAX)

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 RESPONSIBLE PARTY:	Date of Request: