JOSEPH R. RACCUGLIA, MD
family medicine

REQUEST FOR RELEASE OF MEDICAL RECORDS

A request for release of medical records must be signed by the patient or legal guardian, where applicable. Please use a separate form for each requested chart.

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:	Chart ID #:
Address:	City:
State:	Zip Code:
Telephone: ( )	
I hereby authorize the release of my medical record(s) to: Please release: the entire record the record for the following range of dates: _______________ to _______________.	
SIGNATURE OF PATIENT/GUARDIAN:	Date of Request:

02/16/2019

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