Central Jersey Colon and Rectal Surgeons, P.A.

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REQUEST FOR MEDICAL RECORDS TO PATIENT

Please Print Clearly

Patient Name: _____

Address: _____

Date of Birth: _____

I hereby request a copy of my medical records. Please release them to me in the following way:

- ☐ To be picked up by myself
- ☐ To be picked up by _____.

There is a fee of $100.00 for the release of your medical records to you. You will need to pay this fee before the records are released. This can be paid via credit card or personal check made out to Central Jersey Colon and Rectal Surgeons.

Patient Signature: _____ DOB: _____

Print Name: _____ Date: _____

Fax this request to the office: 908 526-5569

Call the office to arrange for pickup and signature release.

By signing this release/waiver you acknowledge that you have received a copy of your medical records.

Date Records Picked up:_____ Pt Signature:_____