1973 Springfield Avenue
Maplewood, NJ 07040

Tel: (973) 313-2501
Fax: (973) 313-2505
Email: info@metroobgynnj.com

Medical Record Release to Patient/Dr's Office:

I _____, date of birth: _____

give consent to Metropolitan OB/GYN, PA to release my medical information to myself or doctors'

office: _____,

Address of office: _____

_____

Phone #: _____ Fax #: _____

Signature: _____ Date: _____

Metropolitan OB/GYN, P.A.
1973 Springfield Avenue
Maplewood, NJ 07040
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Fax: (973) 313-2505

Release Form for Medical Records

Name of Patient: _____

Any other Name: _____

Date of Birth: _____

Social Security #: _____

I _____ hereby give consent for release of my confidential medical records **from** the following physician's office or hospital:

Name of physician or institution: _____

Address of office or hospital: _____

_____

Telephone Number: _____

Fax Number: _____

Dates of service from this office/hospital: _____

I give consent to my medical records to be sent by fax or by mail and I understand that my privacy will be protected and only those records that have been requested will be released.

_____ _____

Signature of Patient Today's Date