METROPOLITAN OB/GYN, PA

1973 Springfield Avenue
Maplewood, NJ 07040

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

Medical Records Request Form

Patient Name: _____

Date of Birth: _____ Phone: _____

_____, hereby give consent for Metropolitan OB/GYN, PA
(Patient Name)

to receive my medical records & any information from the doctors' office below:

Office or Institution: _____

Contact Name: _____

Address: _____

_____

Telephone Number: _____ Fax _____

Dates of service from this office/hospital: _____

What records/results needed: _____

I give consent for my medical records to be sent by fax or by mail to Metropolitan OB/GYN 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

Please send records:
Fax: 973 313-2505 Secure email: info@metroobgynnj.com
Mail: Metro OBGYN 1973 Springfield Avenue Maplewood, NJ 07040 Attn: Records

Please call Medical Records Department 973 313-2501 for any questions