Metropolitan
OB.GYN
1973 Springfield Avenue
Maplewood, NJ 07040

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

Medical Records Release Form

Patient Name: _____

Date of Birth: _____ Phone: _____

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

to release my medical Records to:

❒ Office (Please complete Office information below)

Office _____

Contact: _____

Address: _____

Phone Number _____

Fax Number: _____

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

❒ Self (There is a fee for Printing, $1.00 per page not to exceed $100)

_____ I have received a Print out of my Medical records,
Initial

(paying $1.00 per page not to exceed $100) total Pages _____

The Amount Paid for the records $ _____

Records & Dates Requested: _____

_____ _____

Signature of Patient Today's Date