RECORDS RELEASE REQUEST

Date: ______________________________

To: ____

Address: ____

City:________________________________**State**:___________**Zip**:________________

I hereby authorize and request you to release copies of all___ or part (please specify)

____

of my medical records to:

Michael S. Rogers, MD PA
South Jersey Family Medicine
831 Kings Highway, Suite 100
West Deptford, New Jersey 08096

Telephone: 856-853-8730 **Fax: 856-853-8870**

concerning my illness and/or treatment during the period from__________________

to __________________.

PLEASE PRINT:

Name of Patient____

Address____

____

Telephone______________________________**DOB**____________________________

Signature (Patient, parent, or guardian) _____________________________________

This form expires three (3) months from the date of the request.

Transferring Facility Name: ______________________________________
Contact Person: ____
Telephone: ____