HUNTERDON DIGESTIVE HEALTH Specialists

Patient Record Release Request

(FROM ANOTHER PRACTICE)

Patient Name: _____ Date of Birth: _____

Medical Records requested from:

REQUEST # 1, 2, 3 _____

_____

_____

Information to be released to: **Anubha Sinha 267, US HWY 202/31 South**
Flemington, NJ 08822
Phone: (908)-788-8200 Fax: (908)-788-8207

Please Release the following:

- History, Physical, and Consultation reports
- Progress notes and follow up notes
- Laboratory results
- Pathology results
- X-Ray reports
- Endoscopy reports with biopsies
- Discharge summary
- Surgical operative reports
- **All of the above**
- Any other pertinent information
- _____

For the period from: _____To: _____

Patient Signature: _____ Date: _____

Patient Guardian : _____Date: _____

(if patient is a minor)