



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 170 Route 31
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)