Associates in Primary Care

ASSOCIATES IN PRIMARY CARE, PA
*Internal & Adolescent Medicine*

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# Medical Records Release

DATE: _____

DOCTOR/IMAGING CENTER: _____

LOCATION: _____

P# _____ *FAX# _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

**ASSOCIATES IN PRIMARY CARE, PA**
25 East Willow Street
Millburn, NJ 07041
Phone: (973) 379-5055 Fax: (973) 379-5324

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT TO PRESENT DATE:

*LAB RESULTS
*OFFICE NOTES
*COLONOSCOPY REPORTS
*BREAST IMAGING/MAMMO REPORTS
*FOOT EXAM
*RADIOLOGY REPORTS
*DEXA REPORT
*EYE EXAM
*VACCINE HISTORY
*DIABETIC EYE EXAM
*DIABETIC FOOT EXAM

PATIENT NAME: _____ DOB: _____

_____ _____
*PATIENT'S SIGNTAURE* *DATE*