



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

*FOOT EXAM

*EYE EXAM

*OFFICE NOTES

*RADIOLOGY REPORTS

*VACCINE HISTORY

*COLONOSCOPY REPORTS

*DEXA REPORT

*DIABETIC EYE EXAM

*BREAST IMAGING/MAMMO REPORTS

*DIABETIC FOOT EXAM

PATIENT NAME: _____ DOB: _____

PATIENT'S SIGNATURE

DATE