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: _____