MEDICAL RECORD RELEASE FORM

Lynne B. Kossow, M.D.

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Francis E. Rehor, M.D.

Authorization for Release of Medical Information

Patient Name: _____

DOB: _____

Address: _____

Home Phone: _____

TO: _____ FAX: _____

I hereby authorize and request you to send or fax my medical records to:

Dr. _____ at 731 Alexander Road, Suite 200, Princeton, NJ 08540. Phone: 609-655-3800 Fax: 866-912-7741.

TYPE OF RECORDS REQUESTED:

_____ Complete Medical Record

_____ Immunization Record

_____ Records checked below from the past _____ years

_____ Doctor's Notes/H&Ps

_____ Labs

_____ Colonoscopy/Endoscopy

_____ Xray (Mammo, U/S, MRI, CT, etc)

_____ Medication List

_____ EKG/Stress Test/Echo

_____ Hospital Discharge Summaries

_____

Patient Signature or Legal Guardian