1275 Route 35 North
Middletown, NJ 07748
(732) 275-0999

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE PRINT ALL INFORMATION

NOTE: The purpose of this form is for us to obtain your medical records from your ordering physician in the event we get a denial from your insurance and we must provide proof of medical necessity on your behalf.

Patient's name: ____

Address: ____

City/State/Zip Code: ______________________________________

Home Phone #: ____________________ Date of Birth: ___________

I, ________________________ hereby request you to release my medical records to/from Middletown Medical Imaging Please fax all records to **(732) 275-0979**

Name of Doctor or Organization: ______________________________

Address: ____

Phone #: ____________________ Fax #: ____________________

Signature of Patient or Representative ___________________________

Relationship to Patient: ______________ Date of Request: ___________

Patient's Social Security ________________________