advocare | Premier Ob/Gyn of South Jersey

RECORDS RELEASE INSTRUCTION AND AUTHORIZATION TO RESPOND TO INQUIRIES

To: Dr._____, or to Records

Administrator of_____[hospital or medical facility]

Address: _____

_____

_____

I am the patient named below, and I have executed this form to authorize and direct you or your organization to release originals or copies of all medical records relating to me and to my treatment by you to:

Advocare Premier OBGYN of South Jersey
903 Sheppard Road
Voorhees, NJ 08043
Fax (856) 772-2301

This instruction covers all complete history records in your possession concerning my illness and/or treatment during the period from_____to_____, or **[ ] ALL RECORDS.**

I have requested Advocare Premier OBGYN of South Jersey to assume responsibility for my care. I authorize you to immediately provide to Advocare Premier OBGYN of South Jersey any diagnosis, test results, or other medical information necessary for my safe and continued care pending delivery of such records. By my signature below I authorize you to rely upon an original signature or a facsimile signature, and release you from liability for furnishing information called for by this form to Advocare Premier OBGYN of South Jersey. Thank you for your prompt attention to this matter.

Name [print]:_____Date of Birth: _____

Address:_____Phone: _____

City, State, Zip: _____

Signature:_____Today's Date: _____

Witness: _____

Please return the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.