Monmouth Gastroenterology, LLC

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RELEASE OF MEDICAL RECORDS

Date: _____

To:
_____

_____

_____

Phone: _____Fax: _____

Patient Name:_____ DOB:_____

Check which information you would like released:

- **Release full chart: _____**
- **Release the following reports: _____**
  _____
  _____
- **Reason for release: _____**

I hereby authorize and request your facility to release my medical records to my doctor at Monmouth Gastroenterology.

X_____ X_____
Patient Name (print) Patient Signature