OSCAR T. ORTIZ, MD RONALD B. VILLANUEVA, MD FRANCISCO D. CRUZ, MD

DIABETES, ENDOCRINOLOGY & METABOLISM

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

(Please fill-up only 1 option)

I hereby request that my records be released and sent to:

Name of Provider/Facility_____

Address: _____ City_____

State: _____ Zip: _____ Phone: _____

I hereby request that my records be released from:

Name of Provider/Facility_____

Address: _____ City_____

State: _____ Zip: _____ Phone: _____

I request and authorize you to send my medical records to "Oscar T. Ortiz, MD PC"

Please send information by fax or mail to:

1163 Route 37 West Suite A-1 Toms River, NJ 08755

Phone (732)736-1000 Fax (732)736-8811

TYPE OF RECORDS REQUESTED: (Check all that apply)

_____ Complete Medical Record

_____ Laboratory Report

_____ X-ray Report/Biopsies

_____ Other (please specify) _____

PURPOSE FOR THIS REQUEST: _____

_____ _____

Patient's Signature Date