Records Release Authorization to Mayur V. Patel, M.D.

Date of Request

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Transfer Records from:

Physician/Group: _____

Fax Number: _____

Telephone Number: _____

Address: _____

I, _____ hereby request that you release a complete copy of my medical records to:

Mayur V. Patel, M.D., F.A.C.O.G
Obstetrics & Gynecology

654 Newman Springs Road; Ste. E
Lincroft, NJ 07738
Telephone: (732) 530-1058
Fax: (732) 530-1419

Patient Signature: _____

Address: _____

_____

Patient Phone: _____

Witness Signature: _____

Today's Date: _____