JSRC | JERSEY SHORE RETINA CONSULTANTS

MEDICAL RELEASE FORM

To: _____

_____

_____

I request that you release a complete copy of my medical record, including chart notes, dictated correspondence, photographs and other diagnostic studies. I further request that you release any information about the fact and/or results of AIDS / HIV testing. Please transmit a complete copy to:

Jersey Shore Retina Consultants
241 Monmouth Road
Ste 102
West Long Branch, NJ 07764
Phone: 732-738-4627
Fax: 888-604-9076

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Patient Signature _____ Date _____

Witness _____ Date _____