

MEDICAL RELEASE FORM

NJ Spine and Pain Center
2111 Klockner Road
Hamilton Square, NJ 08690
609-587-6070

To: _____ **Date:** _____

Patient Name: _____ **SS#** _____ - _____ - _____

Date of Birth: ____/____/____ **Telephone#** () _____

Uday N. Bhatt, M.D.
2109-2111 Klockner Road
Hamilton Square, NJ 08690

Please release a copy of my medical records from:

I specifically request the following records authorized for release:

- Dictated H&P
- Initial Office Visit
- Procedure Flow Sheet
- Medication Flow Sheet
- Any CT, MRI or X-ray Report
- Last two office visit

Thank you for you cooperation and prompt attention to this matter.

PATIENT SIGNATURE _____ DATE _____
WITENESS SIGNATURE _____ DATE _____