NORTH DOVER
RADIOLOGY

1215 Route 70 West
Suite 1002-1003
Lakewood, NJ 08701
(732) 370-9902

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PLEASE PRINT ALL INFORMATION

NOTE: The purpose of this form is for us to obtain your medical records from your ordering physician in the event we get a denial from your insurance and we must provide proof of medical necessity on your behalf.

Patient's name: _____

Address: _____

City/State/Zip Code: _____

Home Phone #: _____ Date of Birth: _____

I, _____ hereby request you to release my medical records to/from North Dover Radiology. Please fax all records to **(732) 370-9908**

Name of Doctor or Organization: _____

Address: _____

Phone #: _____ Fax #: _____

Signature of Patient or Representative _____

Relationship to Patient: _____ Date of Request: _____

Patient's Social Security _____