Release of Medical Records

Waters Medical House Calls

TO:_____
_____
_____
_____

Patient Name: _____

Date of Birth: _____ S.S # _____

Address: _____

City: _____ State _____ Zip code _____

I am asking for copies of my medical records related to treatment of all my medical conditions, including but not limited to; History and Physical, Examination Records, Diagnostic Test, Laboratory Results, and Consultation Reports, (rendered by you or under your supervision and/or referred during my entire stay with your practice throughout my last visit) to be released.

I have agreed to receive services from Waters Medical House Calls. Please forward all of my medical records to Waters Medical House Calls to avoid any delay in the continuation of my care.

Waters Medical House Calls
P.O Box 8283
Cherry Hill, NJ 08002

Phone. 856-270-7308 Fax. 856-270-7309

Patient name:_____
Signature: _____ Date _____

POA name: _____
Signature: _____ Date _____

Provider Signature _____ Date _____

Revised 6/4/2018