Lawrenceville Internal Medicine Associates, LLC

Authorization for Release of Medical Information

Patient Name: ____ DOB: ________________

Address: ____ Phone: _______________

____

To:

____
Name of Provider/Facility

____
Address

____
City, State, Zip Code

____
Phone # / Fax # (include area code)

I request and authorize you to send my medical records to **Lawrenceville Internal Medicine Associate, LLC.**

TYPE OF RECORDS REQUESTED: (Check all that apply)
_ Immunization record   _ Laboratory reports _ Other studies (please specify):
_ Pap smear results   _ X-ray reports _______________________
_ Mental Health Records   _ Substance Use treatment
_ Complete Medical Record
_ Other (please specify) ____
____

PURPOSE FOR THIS REQUEST: ____

Please send information by fax or mail to:
Lawrenceville Internal Medicine Associates, LLC
3100 Princeton Pike
Building 4 Suite I
Lawrenceville, NJ 08648

Phone: (609) 896-0303
Fax: (609) 896-0308

________________________________   ________________________
Signature of Patient   Date