Princeton Gastroenterology Associates
731 Alexander Road Suite 100
Princeton, NJ 08540
Telephone (609) 924-1422
Fax (609) 924-7473

Authorization to obtain patient's medical records from a previous physician

Patient name: _____DOB: _____

Telephone number: _____

Patient's previous physician

Physician name: _____

Address: _____
Street City State Zip code

Telephone number:_____

Please release the following medical information to Princeton Gastroenterology Associates at the above address, or by fax to (609) 924-7473:

Dates of service: from _____ to _____
(month / year) (month / year)

_____ Lab results
_____ Radiology Reports
_____ Physician Notes
_____ Discharge Summaries
_____ Operative Reports
_____ EKG, PFT, Cardiac stress test

Patient signature _____ Date _____

If the patient is a minor or otherwise unable to sign this authorization, the signature of the authorized representative is valid.

_____ Signature_____
Relationship of authorized representative to patient