



## The Rubino OB/GYN Group

### Medical Release Form

101 Old Short Hills Road, Suite 101, West Orange, NJ 07052

Tel: 973-736-1100

Fax: 732-396-3262

#### Medical Record Request

This form is a request for The Rubino OB/GYN Group to release medical records for the patient listed below, from the following doctor (check the appropriate box):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Robert J. Rubino, MD  | <input type="checkbox"/> Allan Kessel, MD  | <input type="checkbox"/> Audrey Romero, MD         |
| <input type="checkbox"/> Jacqueline Saitta, MD | <input type="checkbox"/> Lisa Abeshaus, MD | <input type="checkbox"/> Priya Patel, MD           |
| <input type="checkbox"/> Ann-Marie Tang, MD    | <input type="checkbox"/> Dana Ortiz, MD    | <input type="checkbox"/> Jennifer FitzGibbons, APN |

REASON: (check one)  SPECIALIST  MOVING  LEFT PRACTICE

MAMMOGRAPHY FILMS  MAMMOGRAPHY + BREAST ULTRASOUND FILMS

BREAST ULTRASOUND FILMS

Patient's first and last name: \_\_\_\_\_

Patient's current street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Patient's phone #: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Please release my records to the following:

Physician's Fax Number: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Email this medical request form to:**

**medicalrecords@rubinoobgyn.com**