MEDICAL RECORDS TRANSFER REQUEST

Date: _____

Doctor's Name: _____

Address: _____

City, State & Zip: _____

I hereby authorize the release of my medical records and copies of such, and request that they be transferred to:

Lakeview Medical Associates P.C.
125 Route 46 East
Budd Lake, NJ 07828
973-691-1111 Fax 973-691-1198

Nicholas Leggiero, D.O.
Jamie Pietka, M.D.
April Faletto, PA-C

_____ _____

Print name of patient Patient, Parent, or Guardian Signature

_____

Date of Birth