UROLOGY GROUP OF PRINCETON
Patient Medical Record Request

Patient Name: ________________________ Date Records Requested: ___________

Patient Address ________________________ ________________________________
(Street Address) (City, State & Zip Code)

Patient's Date of Birth: ________________ Patient's Social Security # ___________

Fee schedule for copies of medical records: (as determined by N.J.A.C. statute 8:43G-15.3)
1 – 10 Pages $10.00
11 – 100 Pages $1.00 for each additional page
101 – 200 Pages $.25 for each additional page

Record requests are processed daily and are handled in the order in which them are received. You will be notified by mail/fax of the applicable fee for your records. Your records will be sent upon receipt of your payment. Please allow two to three weeks for processing.

Scope of Record Requested – please check one

o **Current pertinent records** (as determined by your physician)

o **Record within a specific time frame**
- o Last 6 months (specify dates) From __________ Through ____________
- o Last 12 months (specify dates) From __________ Through ____________
- o Other time period From __________ Through ____________

o **Specific Reports**
- o Physician's Office notes
- o Laboratory reports
- o Operative report
- o Ultra Sound report
- o Cystoscopy report
- o Other (please specify) ____________________________

o **Entire Medical File**
Including: Progress notes, laboratory results, operative, ultrasound and cystoscopy reports, nursing notes, educational material, surgical scheduling documents, insurance data and misc. correspondence. Your medical file may be larger than you think.

Check one:
If your request is urgent, please provide your fax # for invoicing ______________
o Records to be picked up (you will be notified by telephone when records are ready) Phone # ______________
o Mail records to:

____
Name
____
Street Address
____
City, State, Zip Code

Signature Required _________________________ (Patient/Legally Authorized Representative