MEDICAL RECORDS RELEASE FORM

Ronald Li, MD P.C.
2650 US 130, SUITE B
CRANBURY, NJ 08512

www.drlimd.com
Phone (609) 655-3000
Fax (609) 655-3003

Date: ______________________

Full Name of Patient: ____

Date of Birth: ______________________

Name of Person Requesting Records: ________________________________

Telephone # __________________

Relationship to Patient: ______________________

Please provide me with a copy of my medical records on file with your office.

Reason for Request: ____

Records Requested: ($10 + $1/page for every page above 10 pages – Max $100)

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Name, Address and Telephone # of Person to forward medical records to:

Name: ____

Address: ____

Phone Number: ____

I attest that I have a legal right to these medical records as either the patient or legal guardian:

SIGNATURE ____

I attest that I have a legal right to these medical records as the patient and will allow the following person(s) to pick up my medical records:

__________________________________ PATIENT SIGNATURE _____________________

__________________________________ / ____
PRINTED NAME AND SIGNATURE OF PERSON PICKING UP RECORDS

FEE ______________ ☐ CASH ☐ CHECK # __________ ☐ CREDIT CARD _____________

☐ AT DESK FOR PICKUP ☐ MAILED ☐ OTHER: ____________