# New Jersey Cancer Care, PA
# Medical Record Request Form

**General Medical Records Release and**

## Authorization for Use or Disclosure of Protected Health Information

Date_____

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____Date of Birth: _____/_____/_____

I authorize _____ to
*(Name of Facility)*
disclose/release the following information* (check all applicable):

☐ All records

☐ Laboratory/pathology records

☐ X-ray/radiology records

☐ Radiology images on CD

☐ Billing records

☐ Doctor notes

☐ Pharmacy/prescription records

☐ Pathology report, slides, blocks

☐ Other (describe specifically) _____

**Please send the records listed above to (doctor requesting records):**

___ James Orsini, MD
___ John Conti, MD
___ Said Saleh, MD
___ Leena Bondili, MD
___ James Orsini, Jr., MD
___ Hemalatha Vasireddy, MD
___Sita M. Yerramalli, MD
__ Sana Najib, MD
___ CMMC interventional radiology for biopsy/other procedure

**New Jersey Cancer Care, PA**

_____1 Clara Maass Drive, Suite 200, Belleville, NJ 07109 Phone: 973-751-8880; Fax: 973-751-8950

_____ 1 Bay Avenue, Suite 2, Montclair, NJ 07042 – Phone: 973-744-8000; Fax: 973-744-8340

_____ 776 E 3rd Ave Roselle, NJ 07036 - Phone: 908-259-8817; Fax: 908-259-8846

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Printed name of patient or representative *(i.e. parent, guardian, power of attorney for healthcare, executor)*

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Signature of patient or representative *(i.e. parent, guardian, power of attorney for healthcare, executor)*