

## REQUEST FOR RELEASE OF MEDICAL RECORDS

*FORWARDING RECORDS TO JEFFERSON HEALTH FROM ANOTHER PROVIDER*

Today's Date \_\_\_\_\_

**Physician or Medical Facility Providing Records:**

Name of Physician/Medical Facility: \_\_\_\_\_

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

City, State, Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby request that a copy of my records be released/sent to:

Dr. Loretta Mueller  
The Headache Center  
Jefferson Health  
80 Tanner Street  
Haddonfield, NJ 08033

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Other names under which my account might be located

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

**Please limit medical records release to the following:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- All of the following:
  - Initial headache evaluation notes/report
  - Last 2 years of progress notes
  - List of all current medications and previous medications prescribed
  - All CT/MRI/MRA/MRV reports of the head and neck
  - All EKG's, cardiac testing, and cardiologist reports
  - Last 2 complete blood test reports
  - All specialist reports relevant to headaches

Any and all records available

Any records specifically pertaining to my headache condition

If you have trouble locating my records, I may be reached:

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

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_