Princeton Nassau Pediatrics, P. A.
301 N HARRISON STREET
PRINCETON, NJ 08540
ATTN: RECORDS DEPARTMENT

www.princetonnassaupediatrics.com
609-924-5510

Date:_________________________

Full Name and **Date of Birth** of Patient/s:

____ ____

____ ____

Name of Person Requesting Records: **Relationship to Patient/s:**

____ _______________________________________

Reason for Request: ____

☐ Standard Transfer Packet- $10 Charge
(Includes growth curve, immunization record, specialist letters, radiology reports and a listing of office visits)

OR

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

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Name and Address of person to forward medical records to:

____

____

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 _________________ ☐ PAID ☐AT DESK FOR PICKUP ☐ MAILED OTHER:_____________________________