Request for Release of Medical Records From:

Dr.'s Name: _____

Address: _____

Phone: _____ Fax: _____

I hearby request that my medical records be released to:

MORRIS SUSSEX FAMILY PRACTICE

694 ROUTE 15 SOUTH * SUITE 103 * LAKE HOPATCONG, NJ 07849

973-663-8899

DR. ANTHONY J. LUCATORTO, DO

Please forward the following:

Vaccine Records Last ____ years Other _____

Patient Name (print) _____ Date of Birth: _____

Patient Signature _____ Date: _____