B. Roopali, M.D., F.A.C.O.G.
(Roopali Bhattacharjee)
638 Lawrence Rd., Rt. 206
Lawrenceville, NJ 08648
(609) 883-8200 * Fax (609) 530-1881

MEDICAL RECORD AUTHORIZATION

I hereby authorize the release of my records from B. Roopali, MD, and request that they are released to:

Name_______________________________________

Address_____________________________________

Phone (____) ______________________ Fax (_____) _________________________

Patient Name (print) ________________________________ Signature______________________________

Please remit payment of $________ for the copies of record requested.

(Number of pages __________x ___________per page*) = $________________
Records may be picked up upon calling our office or mailed to you for a fee of $ __________. If medical records are needed for a medical emergency, please have your physician phone our physician.

Please Note:
*N.J.A.C. 13:35 – 6.5 Meeting of Board of Medical Examiners, January 12, 1994, permits a fee for reproduction of medical records at no greater than $1.00 per page or $100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, the physician may charge up to $10.00 to cover the postage and the miscellaneous costs associated with the retrieval of the record.

Office Medical Records

I hereby state that I have received the medical records I requested.

The medical records have been sent to the requested MD

_____________________________________ _____________________________________
Signature Date

Release Information to:-

Organization: ____

Dr. Name: ____

Address: ____

Phone No: ____________________

Fax No: ______________________

Requested Documents to be faxed: __________________________________

____

I hereby authorize Mercer OB/GYN PA to release / disclose the health information listed above.

Patient Signature: ______________________

Date: _____________________________