Medical Record Request

Date: _____

Name of Person Requesting Records: _____

Address: _____
(Street) (City/Zip)

Relationship to Patient: _____ Phone Number: _____

Reason For the Request:

- ☐ Relocating
- ☐ Change of Insurance/ Non-participating In Insurance Plan
- ☐ Transferring Office
- ☐ Personal Records
- ☐ Aged Out

I hereby authorize the release of my children's medical records:

Child's Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

☐ Complete Records
(fee per office policy)

☐ Vaccination Record Only
(no charge, also available on NJIIS registry)

Please call the office to discuss the following options (depending on whether your chart is on paper or in the EMR)

- ☐ Parent(s) will pick up copies of records on paper upon completion. (fee applies, $1/page, $100max)
- ☐ eFax records to new physician ($50 fee). Pls note we can only efax electronic records, not paper files.
- ☐ Download from portal (no fee, access will expire within 30 days of discharge)
- ☐ Mail records to the following address: (fee applies, $1/page, $100max):
  _____

NOTE: Record processing may take up to 30 days from the date of payment.
REACTIVATION OF PORTAL ACCOUNT AFTER 30 DAYS OF DISCHARGE WILL INCUR A $50 FEE

I, the undersigned, agree to all the terms listed above.

Parent/Guardian Signature: _____
Patient Signature (over 18): _____

Office Use Only

Reviewed by Dr. Ciufalo _____

Marisa Ciufalo, MD • 711 Route 10 E • Randolph • NJ • 07869
973-328-9200