

Dr. Robert P. Romano

Bridgeport Family Medicine

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Release of Records

Phone: (304) 848-0338 or Fax: (304) 848-5021

Please release a copy of the following:

- Office / Treatment Notes
- Out-patient Labs/X-Ray/Pathology Reports
- Other: _____

Date Range:

From: _____ To: _____

Request Purpose:

- Medical Insurance Personal
- Legal Other _____

Patient: _____

Date Of Birth: _____ Social Security# _____

Phone# _____

Address: _____

Records Sent From:

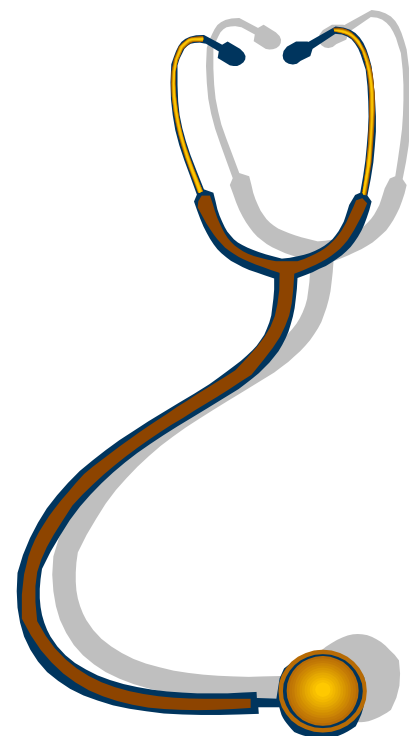
Ph#: _____

Fax#: _____

Records Sent To:

Ph#: _____

Fax#: _____



Signature of Patient / Patient Representative Date

Witness Date

Attention: By signing below you are giving consent for the release of your medical records. These records may be sent by ground transport or electronically via computer or fax machine. If they are received by another party in error you absolve Dr Robert P. Romano Bridgeport Family Medicine of any and all liability relating to such transmission of your records. This consent is valid for six months from the date of your signature. You may revoke this consent by submitting such request in writing prior to the date your records are released. If you have any questions please ask any member of our staff. Thank you.

☆ For additional information please visit our link on...

www.MSMSWV.com