Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Patient Request for Health Information

Patient Information (Please Print):

First Name: Middle Initial: Last Name:			
Name at Time of Treatment (if different):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail:	
Street Address:	City:	State:	Zip:

Which records do you need?

Date(s) of Service: ____/___/___through ___/___/___

Physician's Name and Address: _____

_____

Where do you want the information sent to?

Recipient Name:		
Street Address:	Phone:	Fax:
City:	State:	Zip:

Please print your name and sign below:

Name of Patient or Personal Representative	**Relationship**
Signature	**Date/Time**

Please return completed form to:

Fax: 201-967-0340 Mail: Pascack Valley Medical Center 250 Old Hook Road Westwood, NJ 07675 Attention: Medical Records Department	Questions? Call us at 201-781-1121 There may be charges associated with production of your medical record.