Records Request

Name: ______________________________
Date of Birth: _________________________
Date of Discharge: _____________________

Fill out this records request for in addition to the release of information. If you have any questions please do not hesitate to call the office.

Please provide information about where you would like your records to be sent
Name of person or business: _______________________
Phone #: _____________________________________
Fax #: ______________________________________
Address: _____________________________________
E-mail address: __________________________________

Which records would you like to be sent:

☐All Progress Notes
☐Psychiatric
☐Therapy
☐Treatment Summary
☐Attendance Records
☐Drug Screens
☐Other:
____
____

Date range for records to be released:
____

4 Princess Road, Suite 206, Lawrencville, New Jersey 08648
Office: (609)482-3701 Fax: (609)482-3702