

Request for Release of Medical Records From:

Dr.'s Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby request that my medical records be released to:

MORRIS SUSSEX DIRECT FAMILY PRACTICE

28 Bowling Green Parkway * Suite LL3 * Lake Hopatcong, NJ 07849

PHONE: 973-663-8899 FAX: 973-663-9511
www.MorrisSussexDPC.com

Dr. Anthony J. Lucatorto, D.O.

Please forward the following:

ALL Medical Records 3 years 5 years Complete Record

Vaccine Records Other: _____

Patient Name: _____

Date of Birth: _____

Patient Signature : _____ Date: _____