Ridgewood Orthopedic Group

Record Release Form

Patient's Name and DOB _____ Date Requested _____

Received From: _____

Initials (Office Use) _____

- ☐ Dr. Arnold Criscitiello
- ☐ Dr. Anthony Delfico
- ☐ Dr. Mark Pizzurro
- ☐ Dr. Andrew Brief
- ☐ Dr. Kevin Roenbeck
- ☐ Dr. Umer Dasti
- ☐ Dr. Ismar Dizdarevic
- ☐ Dr. Lauren Terranova
- ☐ Dr. Louis Amorosa
- ☐ Jennifer L. Ormsby, PA-C
- ☐ Nerricka V Nalundasan, PA-C
- ☐ Claudia J Lucas, PA-C
- ☐ Nirali Patel, PA-C
- ☐ Diana Cronenberg, PA-C
- ☐ Jessica DeLeon, PA-C
- ☐ Allison M. Makowsky, MSN, APN, NP-C

Dates/date range requested:

- ☐ X-RAYS _____
- ☐ RADIOLOGY/ LAB REPORTS _____
- ☐ OFFICE NOTES/OTHER _____

Method of Receipt: ◯ **encrypted email** ◯ **Non-encrypted email** ◯ **Mail** ◯ **Fax**

Email: _____ Address: _____ Fax #: _____

*If recipient is other than the patient, please give name, relationship, and address of recipient:

Recipient Name: _____

Recipient Relationship: _____

Recipient Address: _____

Patient's Signature: _____

Regardless of who picks up the requested information, we must have the PATIENT's signature either on this form or on a separate note requesting the release. This information and/or images have been copied into our computers. Unless our office has specifically requested that you return the records, they are yours to keep; please do not return them. Place the records in a safe location for future reference if necessary.