RECORD TRANSFER REQUEST

To: Deborah L. Ungerleider, M.D., LLC
44 Godwin Ave Suite #100
Midland Park, NJ 07432

Date________________________________

Patient's Name____

Date of Birth____

_____Please release my medical records to:
(if 18 years or older)

_____Please release my son's/daughter's medical records to:
(if under 18 years)

Doctor's name_____________________________________

Doctor's address____________________________________

____

Phone #____

Thank you,

____
(Parent Signature or Patient Signature if over 18 years old)

____
(Print name)