The Headache Center at
Kennedy Health Alliance
457 Haddonfield Road, Suite 110
Cherry Hill, New Jersey 08002
Phone: (856) 406-4091
Fax: (856) 406-4570

REQUEST FOR RELEASE OF MEDICAL RECORDS

FORWARDING RECORDS TO KENNEDY HEALTH ALLIANCE FROM ANOTHER PROVIDER

Today's Date _____

Physician or Medical Facility Providing Records:

Name of Physician/Medical Facility: _____

Address: _____ Telephone: _____

_____

City, State, Zip Code: _____ Fax: _____

I hereby request that a copy of my records be released/sent to:

Dr. Loretta Mueller
The Headache Center
Kennedy Health Alliance
457 Haddonfield Rd, Suite 110
Cherry Hill, New Jersey 08002

_____
Patient Signature

_____
Printed Name

_____ _____
Date of Birth Social Security Number

_____
Other names under which my account might be located

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Name:_____

Please limit medical records release to the following:

☐ _____
_____
_____
_____
_____
_____

☐ All of the following:
- Initial headache evaluation notes/report
- Last 2 years of progress notes
- List of all current medications and previous medications prescribed
- All CT/MRI/MRA/MRV reports of the head and neck
- All EKG's, cardiac testing, and cardiologist reports
- Last 2 complete blood test reports
- All specialist reports relevant to headaches

☐ Any and all records available

☐ Any records specifically pertaining to my headache condition

If you have trouble locating my records, I may be reached:
Home Address: _____
_____
_____
Home Phone: _____ Work/Cell: _____