REQUEST FOR RELEASE
OF
MEDICAL RECORDS

TO:_____
Physician's Name

_____
Address

_____

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

CENTER FOR COLON & RECTAL HEALTH, INC.
RICHARD S. GOLDSTEIN, M.D.
ANNE-MARIE MARCOUX, M.D.
DAVID M. SCHAFFZIN, M.D.

St. Mary Medical Center
St. Clare Medical Building - Suite 130
1203 Langhorne-Newtown Road
Langhorne, PA 19047

_____
Patient's Signature

_____
Patient's Name

_____
Address

_____

_____
Patient's Date of Birth