



**MEDICAL RELEASE FORM**

**Baher S. Yanni, M.D**

To: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone# (     ) \_\_\_\_\_

Baher Yanni, M.D  
4 Cornwall Dr. Suite 221  
East Brunswick, N.J 08816

Please release a copy of my medical records from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I specifically request the following records authorized for release:

- |  |  |
|--|--|
| <input type="checkbox"/> Dictated H&P                | <input type="checkbox"/> Initial Office Visit  |
| <input type="checkbox"/> Procedure Flow Sheet        | <input type="checkbox"/> Medication Flow Sheet |
| <input type="checkbox"/> Any CT, MRI or X-ray Report | <input type="checkbox"/> Last two office visit |

**Thank you for you cooperation and prompt attention to this matter.**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_