



WINDSOR CENTER
FOR DIGESTIVE HEALTH
 Gastroenterology. Nutrition. Wellness.

Release of Medical Records

To: _____

Address: _____

Phone #: _____

Fax#: _____

I, _____ authorize the release of my medical records to Windsor Center for Digestive Health. Please fax these records to:

Vasudha Dhar, M.D.

Windsor Center for Digestive Health

300B Princeton Hightstown Road, Suite 206

East Windsor, NJ 08520

Phone: 609-918-1222

Fax: 609-918-1235

Patient Name: _____

Date of Birth: _____

Office Notes

Pathology

Labs/Bloodwork

Colonoscopy Report

CT Scans

Endoscopy Report

Ultrasound Reports

Other: _____

Patient Signature: _____

Date: _____