REQUEST FOR RECORDS RELEASE

TO: _____

DOCTOR/HOSPITAL

_____

ADDRESS

I hereby authorize and request you to release to:

ALL CARE PEDIATRICS

90 Millburn Ave., Suite 101, Millburn, NJ 07041
Tel # 973-378-7990 · Fax # 973-378-7991
allcarepediatricsnj.com

the complete history records in your possession concerning my illness and/or treatment during the period from _____ to_____.

Patient's Name: _____ DOB: _____

Guardian: _____ Rel. To Pt: _____

Address: _____

Signature: _____ Date Signed: _____