

**Record Release Authorization**

TO: \_\_\_\_\_

Doctor or Hospital

\_\_\_\_\_  
Address

FAX : \_\_\_\_\_

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

**HEALTHY KIDS PEDIATRICS**

Dr. Jill Garripoli Pedalino,  
Dr. Rachelle Namm, and Dr. Eileen Torres

675 Franklin Ave.  
Nutley, NJ 07110  
Telephone (844) 437-5455  
Fax (862) 238-7454

THE ENTIRE MEDICAL RECORD (INCLUDING VACCINES/LABS/OFFICE NOTES) IN  
YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE  
PERIOD FROM:

\_\_\_\_\_ TO \_\_\_\_\_

NAME(S) & DATE OF  
BIRTH: \_\_\_\_\_

ADDRESS \_\_\_\_\_

—

PHONE \_\_\_\_\_

—

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_