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, and Dr. Yie-Hsien Chu

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_____