160 Pehle Avenue, Suite 302
Saddle Brook, NJ 07663

TEL: (201) 252-8700
FAX: (201) 252-8701

Records Release Authorization

I authorize and request the release of my child/children's medical records.

Child/Children's Name(s): _____

Child/Children's Date of Birth: _____

_____ _____
Signature of Parent Date

_____ _____
Signature of Patient (if over the age of 18) Date

There Is a charge to cover costs associated with copying/printing records. Per NJ regulations, these fees are $1.00 per page or $100 for an entire record, whichever is less. You will only be billed when the record review is complete and ready to be mailed. Records cannot be released until payment is made. For the most efficient release process, please use a credit card. Please allow up to 30 days for us to prepare your records.

TODAY'S CHARGE: _____

Card # _____

Exp. Date _____ Security No. _____

CIRCLE ONE

_____ _____
Signature Date

Please select how you would like your records to be transferred:

□ I will pick up my records. Please call this number when ready: _____

□ Please, mail my records to the following address: (Additional shipping charges might apply).

_____

_____

_____

Reason for transfer: (If due to insurance change, please indicate new plan).____