Record Release Authorization

To: _____
(Doctor or Hospital)

Address: _____

_____

_____

I hereby authorize and request the release of the complete records in your possession concerning my/my child's treatment from _____ to _____:

Please send to the circled address below:

MIDDLETOWN PEDIATRICS

529 Highway 35
Red Bank, NJ 07701
Tel: 732-741-9800
Fax: 732-758-6367

812 Poole Ave Ste. A
Hazlet, NJ 07730
Tel: 732-888-0010
732-888-0012

www.middletownpediatrics.com

Name: _____ Date:: _____

Address: _____

_____

_____

Signature: _____

Witness: _____

Relationship to Patient _____