

## **Record Release Authorization**

(Doctor or Hospital)  Address:	To:		
I hereby authorize and request the release of the complete records in your possession concerning my/my child's treatment from	(Doc	ctor or Hospital)	
I hereby authorize and request the release of the complete records in your possession concerning my/my child's treatment from	Address:		
I hereby authorize and request the release of the complete records in your possession concerning my/my child's treatment from			
I hereby authorize and request the release of the complete records in your possession concerning my/my child's treatment from			
my/my child's treatment from to			
my/my child's treatment from to			
my/my child's treatment from to			
Please send to the circled address below:   MIDDLETOWN PEDIATRICS     529 Highway 35	•	-	· · ·
MIDDLETOWN PEDIATRICS   529 Highway 35   812 Poole Ave Ste. A   Red Bank, NJ 07701   Hazlet, NJ 07730   Tel: 732-741-9800   Tel: 732-888-0010   Fax: 732-758-6367   732-888-0012	my/my child's tre	eatment from to _	:
MIDDLETOWN PEDIATRICS   529 Highway 35   812 Poole Ave Ste. A   Red Bank, NJ 07701   Hazlet, NJ 07730   Tel: 732-741-9800   Tel: 732-888-0010   Fax: 732-758-6367   732-888-0012			
529 Highway 35	Please send to the	e circled address below:	
Red Bank, NJ 07701		MIDDLETOWN	PEDIATRICS
Red Bank, NJ 07701		529 Highway 35	812 Poole Ave Ste. A
Tel: 732-741-9800 Tel: 732-888-0010 Fax: 732-758-6367 732-888-0012  www.middletownpediatrics.com  Name: Date::  Address:  Signature:  Witness:			
Fax: 732-758-6367			•
Name: Date::  Address:  Signature: Witness:			
Name:			
Address:  Signature:  Witness:		www.middlet	ownpediatrics.com
Address:  Signature:  Witness:			
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Relationship to Patient	witness:		<del></del>
	Relationship to P	Patient	