AUTHORIZATION TO RELEASE RECORDS

From:

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I, ________________________________, authorize release of complete office records, including laboratory reports, radiology reports, and hospital discharge summaries for

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Date of Birth______________________________________

To:

My Whole Child Pediatrics
<Location Drop Down>
<Values : Piscataway, Edison, Elizabeth, New Brunswick, North Brunswick >
<Location Full Address with Phone & Fax #>

Signature: ______________________ Relationship: _________________

Witness: ______________________ Date: _______________________