Record Release Authorization

To: ______________________________
(Doctor or Hospital)

Address: ____

____

____

Fax #: ____

I hereby authorize and request the release of the complete records (including but not limited to vaccines, labs, and office notes) in your possession concerning my child's treatment from ____________ to ______________:

Please send to the circled address below:

PANDA PEDIATRICS

3635 Quaker Bridge Road, Suite 3
Hamilton, NJ 08619
Tel: 609-807-8988

www.pandapediatricsnj.com

Name:s) & Date of Birth: ____

____

Guardian's Name: ____ Date: _________________

Address**:** ____

____

____

Signature: ____

Witness: ____

Relationship to Patient ______________________________________