Authorization to Release Medical Records

I authorize _____(practice)

Address:_____

Phone #_____ Fax#_____

to release the medical records of :

Patient:_____ DOB_____

Address:_____ Phone #_____

To:

AMAZING KIDS PEDIATRICS LLC

299 Forest Avenue (Third Floor)

Paramus, NJ 07652

Phone # 201-267-0890

Fax# 201-483-8874

I fully understand that these records are protected under federal/state law and cannot be discloses without my written consent.

By my signature below I knowingly and voluntarily authorize Amazing Kids Pediatrics LLC to request my health information.

Signature of Patient/Parent/Guardian _____

Relationship to Patient _____

Date_____