

RECORDS RELEASE AUTHORIZATION

TO:

Doctor or Hospital

Date

Fax Number

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE TO SOMERSET PEDIATRIC GROUP,

- 2345 Lamington Road, Suite 101, Bedminster, NJ 07921
- 317 Cleveland Ave, Suite 204, Highland Park, NJ 08904
- 1-C New Amwell Road, Hillsborough, NJ 08844
- 1390 Route 22 West, Suite 106, Lebanon, NJ 08833
- 59 East Mill Road, Suite 10, Long Valley, NJ 07853
- 575 Route 28, Suite 2100, Raritan, NJ 08869
- 150 Morris Avenue, Suite 303, Springfield, NJ 07081
- 2 World's Fair Drive, Suite 302, Somerset, NJ 08873
- 65 Mountain Blvd Ext., Suite 205, Warren, NJ 07059

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM:

_____ TO _____

PATIENT'S NAME _____

DATE OF BIRTH _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____