PediatriCare Associates
Pediatric and Adolescent Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

I, _____, do hereby authorize PediatriCare Associates to obtain all medical records pertaining to the patient (s) listed below.

Patient Name:

1. . _____ DOB _____
2. _____ DOB _____
3. _____ DOB _____
4. _____ DOB _____
5. _____ DOB _____

Mail or Fax Records to: _____

_____

_____

I hereby authorize disclosure of the health information for the above names patient(s). This authorization is valid for 12 months from the date of signature. I understand that they legally have 30 days to release my records. I also understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation.

_____
(Signature of parent/legal guardian)

_____
(Phone number to call when records are ready)

20-20 Fair Lawn Avenue
Fair Lawn, NJ 07410
Phone: (201) 791-4545
Fax: (201) 791-3765

400 North Franklin Turnpike
Mahwah, NJ 07430
Phone: (201) 529-4545
Fax: (201) 529-1596

901 Route 23 South
Pompton Plains, NJ 07444
Phone: (973) 831-4545
Fax: (973) 831-1527

1225 McBride Ave
Woodland Park, NJ 07424
Phone: (973) 256-4545
Fax: (973) 826-8600