Patient Authorization For Release And Disclosure of Medical Records/

Protected Health Information (PHI)

To,

_____

_____

_____

_____

_____

Please release records for _____,

_____ and _____

And forward them to:

Central Jersey Pediatrics
1553 Ruth road, Suite 1, North Brunswick, NJ-08902
Ph. : 732-418-1700, Fax. : 732-940 9700
1300 How Lane, North Brunswick, NJ-08902
Ph. : 732-247-1510, Fax: 732-247-8885

As soon as possible.

Signed: _____ Print: _____ DT. _____

Witness _____ Print: _____ DT. _____