Patient Authorization For Release And Disclosure of Medical Records/

Protected Health Information (PHI)

To,

_____

_____

I, _____, hereby authorize and request you to release the complete medical records including information regarding any medical conditions, physical exams, lab results, treatments, immunizations, venereal disease, genetic disease, pregnancy, HIV related, or any other relevant medical details, for the following patients:

	Patient Name:	Date of Birth:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

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: _____ Date: _____

Witness _____ Print: _____ Date: _____