RECORDS RELEASE AUTHORIZATION

TO: ____
DOCTOR OR HOSPITAL

____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

BAYSIDE PEDIATRIC SPECIALISTS, P. C.
23-25 BELL BLVD.
BAYSIDE, N. Y. 11360
(718) 225-6464 - Phone
(718) 225-9316 - Fax

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND / OR TREATMENT DURING THE PERIOD FROM ______________ TO ______________

NAME ______________________________ DATE ______________

ADDRESS ____

SIGNATURE ______________________________ WITNESS ______________________________
(IF RELATIVE, STATE RELATIONSHIP)

119-P