

PEDIATRIC AFFILIATES, P.A.
SPECIALIZING IN INFANTS, CHILDREN AND ADOLESCENT MEDICINE

RECORDS RELEASE REQUEST

I authorize **PEDIATRIC AFFILIATES, P.A.** to release all medical records pertaining to:

Patient's Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____ **Phone:** _____

Pick Up: _____ **or Mail To:** _____

Reason for Request: _____

Please Specify:

Complete Chart: _____ **OR** **Shots Only:** _____

- Please be advised that there will be a \$1.00 per page copying fee which is due at time of pick up.
- Records requests can take up to 30 days to complete

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

Relationship to Patient

Witness

02/2015

TOMS RIVER 40 BEY LEA RD, B203 TOMS RIVER, NJ 08753 TEL: 732.341.0720 FAX: 732.244.6842	LAKWOOD 400 MADISON AVE LAKWOOD, NJ 08701 TEL: 732.364.7770 FAX: 732.364.9292	MANAHAWKIN 1616 Rt 72 WEST MANAHAWKIN, NJ 08050 TEL: 609.597.6200 FAX: 609.978.1229	HOWELL 1001 RT 9 NORTH HOWELL, NJ 07731 TEL: 732.905.9166 FAX: 732.431.9105	BRICK 218 JACK MARTIN BLVD BRICK, NJ 08724 TEL: 732.458.0010 FAX: 732.458.9329	LAKWOOD 870 RIVER AVE LAKWOOD, NJ 08701 TEL: 732.367.3700 FAX: 732.367.3727
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