PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN AND ADOLESCENT MEDICINE

AUTHORIZATION TO OBTAIN RECORDS

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

Patient's Name: ______________________________________ **Date of Birth:** ______ / ______ / ________

Address: ____ **Phone:** ____________________________

(Street Name)

____

(City, State, Zip)

From: ____ ___________________________________

(Location) **(Phone)**

____ ___________________________________

(Address) **(Fax)**

____

(City, State, Zip)

Complete Chart: ____________________ **OR** **Shots Only:** _________________________

____ ______________________________

Signature of Patient or Patient's Representative **Date**

____ ______________________________

Printed Name of Patient or Patient's Representative **Relationship to Patient**

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Witness

Please MAIL Complete Charts to: Pediatric Affiliates, PA
40 Bey Lea Road, B203
Toms River, NJ 08753
732-341-0720

Please FAX Shot Records to: Records Office – 732-244-6842

12/2015