

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**

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

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| TOMS RIVER 40 BEY LEA RD, B203 TOMS RIVER, NJ 08753 TEL: 732.341.0720 FAX: 732.244.6842 | LAKWOOD 400 MADISON AVE LAKEWOOD, 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 LAKEWOOD, NJ 08701 TEL: 732.367.3700 FAX: 732.367.3727 |
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