Record Release Authorization

To: ____

Doctor or Hospital

____

Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

OLD TAPPAN PEDIATRCS

Harry A. Hages, M.D.
Nancy Rothenberg, D.O.
Ann DeAngelo, M.D.
Perry Fishkind, M.D.

215 Old Tappan Rd.
Old Tappan, NJ 07675

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

______________________ TO _______________________

NAME(S): ____

ADDRESS: ____

SIGNATURE: ____ DATE: __________________________