Record Release Authorization

To:_____
Doctor or Hospital

_____
Address

Fax #_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

BROADWAY PEDIATRIC ASSOCIATES
Daniel I Schwartz, M.D. F.A.A.P.
Katrina Munteanu, M.D. F.A.A.P.
Jaclyn Fallon, D.O. F.A.A.P.

336 Center Avenue
Westwood, NJ 07675

Telephone (201) 664-7444
Fax (201) 666-9476

THE ENTIRE MEDICAL RECORD (INCLUDING VACCINES/LABS/OFFICE NOTES) IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM

_____TO_____

NAME(S) & Date of Birth: _____

_____

ADDRESS_____

PHONE_____

SIGNATURE_____ Date_____