REQUEST FOR RECORDS RELEASE

TO: ____

DOCTOR/HOSPITAL

____

ADDRESS

I hereby authorize and request you to release to:

LARRY GRUENWALD, M.D., F.A.A.P.
ANN MARIE COMANDATORE, M.D., F.A.A.P.
MARA STERIO, M.D., PhD., F.A.A.P.
ANDREA ALEXANDER, M.D., F.A.A.P.
STACY THOMPSON, D.O., F.A.A.P.
SHARON SPITERI, M.D., M.P.H. F.A.A.P.
YANINA MESHKO, M.D., F.A.A.P.
SHRUTI RAMESH, D.O., M.P.H., F.A.A.P.

90 Millburn Ave., Suite 101 Millburn, NJ 07041
Telephone: (973) 378-7990 • Fax: (973) 378-7991

the complete history records in your possession concerning my illness and/or treatment during the period from _______________ to _______________.

Patient's Name: ______________________________ DOB: ____________________

Guardian: ______________________________ Rel. To Pt: ____________________

Address: ____

Signature: ______________________________ Date Signed: ____________________

(PARENT/GUARDIAN or PATIENT, if at least 18 years old)