BRIELLE PEDIATRICS

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REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

NAME and DOB: ____________________________

NAME and DOB: __________________________

NAME and DOB: ____________________________

NAME and DOB: _________________________

RELEASE RECORDS FROM:

OFFICE: _____________________________

ADDRESS: ____________________________

PHONE: ______________________________

FAX: _________________________________

RELEASE RECORDS TO: BRIELLE PEDIATRICS, 105 UNION AVENUE, BRIELLE, NJ 08730

Fax: 732-800-3203

PLEASE RELEASE THE FOLLOWING RECORDS:

____ OPERATIVE REPORTS ____ PRENATAL/HOSPITAL DISCHARGE RECORDS ____ LAB REPORTS

____ PROGRESS REPORTS ____ RADIOLOGY REPORTS ____ ALL RECORDS

__X__ IMMUNIZATION RECORD OTHER (Please specify) ____

____ I **ALLOW** INFORMATION TO BE TRANSMITTED BY FAX. I UNDERSTAND THAT THIS MAY LIMIT THE SECURITY OR CONFIDENTIALITY OF THE RECORDS.

____ I **DO NOT ALLOW** INFORMATION TO BE TRANSMITTED BY FAX.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

_________________________________ (PATIENT SIGNATURE)

_________________________________ (DATE OF AUTHORIZATION)