

RECORDS RELEASE AUTHORIZATION

TO: _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

BROADWAY PEDIATRIC ASSOCIATES

MARY LEE HARRISON, M.D., F.A.A.P.

DANIEL I. SCHWARTZ, M.D. F.A.A.P.

DARYL O'BRIEN, M.D. F.A.A.P.

MARY H. CLARK, M.D. F.A.A.P.

335 CENTER AVENUE

WESTWOOD, NJ 07675

TELEPHONE (201) 664-7444

FAX (201) 666-9476

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS

AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____

(IF RELATIVE, STATE RELATIONSHIP)