AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE _____ (Doctor/Practice/Hospital)

Address: _____

Phone: _____ Fax: _____

TO RELEASE THE COMPLETE MEDICAL RECORDS OF:

Patient: _____ Date of Birth: _____

Address: _____ Phone: _____

TO:

BRIDGE PEDIATRICS LLC

2175 LEMOINE AVENUE

SUITE 502

FORT LEE, NJ 07024

P: (201) 585-7337

F: (201) 585-7333

info@bridgepediatricsnj.com

I fully understand that these records are protected under federal and state law and cannot be disclosed without my written consent.

I authorize Bridge Pediatrics LLC to request my/ my child's health information.

Signature of Patient/ Parent/ Guardian _____

Relationship to Patient _____

Date_____ Witness_____