RECORDS RELEASE AUTHORIZATION

TO: _____

Doctor or Hospital

_____ _____

Date Fax Number

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

SOMERSET PEDIATRIC GROUP, P.A.

- ☐ 2345 Lamington Road, Suite 101, Bedminster, NJ 07921
- ☐ 155 Union Avenue, Bridgewater, NJ 08807
- ☐ 385 Route 24, Suite 1-B, Chester, NJ 07930
- ☐ 1-C New Amwell Road, Hillsborough, NJ 08844
- ☐ 1390 Route 22 W., Suite 106, Lebanon, NJ 08833
- ☐ 2 World's Fair Drive, Suite 302, Somerset, NJ 08873
- ☐ 65 Mountain Blvd. Ext., Suite 205, Warren, NJ 07059

THE COMPLETE MEDICAL RECORDS IN YOUR POSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE

PERIOD FROM: _____ TO: _____

Patient's Name: _____ Date of Birth: _____

Signature: _____ Relationship: _____

9/16