New Jersey Pediatric and Adolescent Care, LLC

Release of Medical Records

☐ I authorize a complete copy of my child's medical records to be forwarded to:

New Jersey Pediatric and Adolescent Care, LLC

1680 Route 23 North, Suite 350

Wayne, NJ 07470

☐ I authorize New Jersey Pediatric and Adolescent Care to forward a copy of my child's medical records to:

Physician/Practice: _____

Address: _____

Phone Number: _____ Fax Number: _____

Please list each child whose medical record is being requested:

Patient Name(s)	Date of Birth
_____	_____
_____	_____
_____	_____

Reason for transfer:

☐ Change of Medical Provider

☐ Moving/Relocation

☐ Other _____

I understand that this authorization is valid one year from today's date but that I can revoke it in writing at any time.

Signature: _____ Date: _____