Authorization for Release of Medical Records

Attention: ____

Address: ____

____

Phone: ____________________________ Fax: ______________________

Please release a complete copy of my child's medical records to:

Brighton Pediatrics
3069 English Creek Avenue
Suite 302
Egg Harbor Township, NJ 08234
Phone: (609) 383-3800
Fax: (609) 383-3839

Patient's Complete Name: ____

Date of Birth: ____

Please mail/fax these records for an appointment on: ____________________

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Witnessed By____

Date: ____