AUTHORIZATION TO RELEASE RECORDS

TO:

_____

_____

_____

_____

I, _____, authorize release of complete office records, including laboratory reports, radiology reports, and hospital discharge summaries for

_____

Date of Birth _____

To:

Dr. Naveen Mehrotra,MD,PA
My Whole Child Pediatrics
652 Amboy Avenue
Edison, NJ 08837
(732) 738-1341
(732) 738-9585 (fax)

Signature: _____Relationship: _____

Witness: _____Date: _____