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
171 Elmora Avenue, 3rd Fl
Elizabeth, NJ 07202
908-289-2239
908-659-1001 (fax)

Signature: _____Relationship: _____

Witness: _____ Date: _____