
# 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**
1315 Stelton Road
Piscataway, NJ 08854
732-819-8800
732-819-8801 (fax)

Signature: _____Relationship: _____

Witness: _____ Date: _____