AUTHORIZATION TO RELEASE RECORDS

To:

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

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Date of Birth____

To:

Dr. Naveen Mehrotra, MD, PA
My Whole Child Pediatrics
1555 Ruth Rd, Suite 4
North Brunswick, NJ 08902
Ph (732) 398-0900
Fax (732) 398-9030

Signature: _____________________ Relationship: _________________

Witness: ______________________ Date: _______________________