

RECORD RELEASE AUTHORIZATION

TO-

I hereby authorize and request you to release my children's records to:

Silverton Pediatrics, LLC
Rumana Qazi, M.D. Shirley Ulep, M.D.
Chris Patestos, M.D. Valerie Sia, M.D.
1314 Hooper Avenue
Bldg A, 2nd Floor
Toms River, New Jersey 08753
Telephone: 732-255-7553 Fax: 732-255-8901

The complete history records in your possession, concerning my illness and/ or treatment during the period from _____ to _____.

Patients Name:

Date of Birth:

Signature: _____ Date: _____

*****If more than 10 pages please mail chart and do not fax*****