Record Release Authorization

To-

_____

_____

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

Silverton Pediatrics
Rumana Qazi, M.D. Shirley Ulep, M.D.
Chris Patestos, M.D. Valerie May Sia, M.D.
Mariane Ibrahim, M.D.
1314 Hooper Avenue
Bldg A, 2nd Floor
Toms River, NJ 08753
T: 732-255-7553 F:732-255-8901

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

Patients Names: Date of Birth:

_____

_____

_____

_____

_____

Signature:_____Date:_____

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