RECORD RELEASE AUTHORIZATION

Please List Previous Physician Below:

Name:_____ **Phone:**_____

Address:_____ **Fax:**_____

I hereby authorize and request you to release my child(ren)'s records to:

Silverton Pediatrics, LLC
Rumana Qazi, M.D. Shirley Ulep, M.D.
Chris Patestos, M.D. Valerie Sia, M.D.
Mariane Ibrahim, M.D. Reza Razvi D.O
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 _____.

Patient's Name:	Date Of Birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Print Name/Relationship to Patient(s):_____

*******If more than 10 pages, please mail records and do not fax.******