Incoming Record Release Authorization

To-

Name of office/Dr. Phone:

Address: Fax:

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

Silverton PEDIATRICS

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 _____.

Patient(s) Names: Date(s) of Birth:

Signature:_____ Date:_____

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