PEDIATRIC SPECIALTIES, P.A.
90 PROSPECT AVENUE
HACKENSACK, NJ 07601
201-342-4001

RECORD RELEASE FORM

I hereby authorize and request that you release the complete medical records of:

Name: _____ Date: _____

Address: _____

_____

Phone: _____

Signature: _____

Witness: _____

To: _____

_____

_____

I understand that there is a charge of $1.00 per page or $20.00 minimum for this service. It may take up to 30 days to process your request.

Reason for record request:

_____
_____
_____
_____
_____