HAMILTON PEDIATRIC ASSOCIATES, PC
3 HAMILTON HEALTH PLACE
SUITE A
HAMILTON, NJ 08690
P – 609-581-4480
F – 609-581-5222

RELEASE OF MEDICAL RECORDS

DATE:_____

CHILDS NAME:_____ DOB: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

I HEARBY AUTHORIZE THE RELEASE OF MY CHILD'S MEDICAL RECORDS

TO:_____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

PLEASE CHECK ONE:

_____ I AM TRANSFERRING TO A DIFFERENT PRIMARY CARE PHYSICIAN

_____ I AM MOVING OUT OF THE AREA

_____ I WOULD LIKE RECORDS SENT TO A SPECIALIST FOR REVIEW

REQUESTOR SIGNATURE_____

RELATIONSHIP TO CHILD _____

PHONE NUMBER _____