Medical Record Release Authorization

Transfer medical records to Healthy Pediatrics at Old Bridge, LLC
3 Athens Avenue, South Amboy, NJ 08879
Phone: 732-952-8400 Fax: 732-952-8402

Previous Practice or Physician's Name: _____
Address: _____
City, State, Zip Code: _____
Phone/Fax: _____/_____

Dear Dr. _____:
(Previous Physician's Name)

I _____ hereby authorize _____ the transfer of
(Patient's Name) (Previous Practice or Physician's Name)

my medical records to Healthy Pediatrics at Old Bridge, LLC.

Specific information to be used and/or disclosed:

- ☐ All Records
- ☐ Immunization Records
- ☐ Growth Charts
- ☐ Laboratory/Radiology Reports
- ☐ Specialist Reports
- ☐ Other:_____

Sincerely Yours,

Name: _____/ X _____
Patient or Authorized Representative Signature

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian Date: _____

Patient's Name:_____ D.O.B. _____