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INFANTS, CHILDREN AND ADOLESCENTS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ hereby authorize:
(Parent/Guardian: Please print name)

UNIVERSITY PEDIATRIC ASSOCIATES, P.A.

- 317 Cleveland Avenue, Suite 204, Highland Park, NJ 08904. Phone: (732) 249-8999 Fax: (732) 249-7827
- D-1 Brier Hill Court, East Brunswick, NJ 08816. Phone: (732) 238-3310 Fax: (732) 613-6051

To release medical records on:

<u>Patient Name</u>	<u>Birth Date</u>
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

Release To:

Name(s): _____ Address: _____ City, State, Zip: _____ Current Phone#: _____
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****If moving please provide change of address and current phone #****

Signature: X _____

Print Name: _____

Date: ____/____/____

Why are you leaving: _____

******Any current insurance balance not covered by insurance will become the responsibility of the insured.******