Tenafly Pediatrics, P.A.

Pediatrics & Adolescent Medicine

Medical Release Form

Practice/Doctor's Name:_____

Address:_____

Phone # _____ **Fax #** _____

to release Medical Records as follows:

PATIENT'S NAME	D.O.B.

Physician/Facility to receive records:

- ❑ **32 Franklin Street • Tenafly, N.J. 07670 (201) 569-2400 • Fax: (201) 569-6081**
- ❑ **301 Bridge Plaza No. • Fort Lee, N.J. 07024 (201) 592-8787 • Fax: (201) 592-6350**
- ❑ **26 Park Place • Paramus, N.J. 07652 (201) 262-1140 • Fax: (201) 261-8413**
- ❑ **1135 Broad Street • Clifton, N.J. 07013 (973) 471-8600 • Fax: (973) 471-3068**
- ❑ **350 Ramapo Valley Road • Oakland, N.J. 07436 (201) 651-0404 • Fax: (201) 651-0909**
- ❑ **74 Pascack Road • Park Ridge, N.J. 07656 (201) 326- 7120 • Fax: (201) 326-7130**
- ❑ **333 15th Street • Hoboken, N.J. 07030 (201) 482-9770 • Fax: (201) 482-9780**

Please sign below as the responsible party for the above named patient(s) Medical Records.

_____ Signature of Authorized Person

_____ Relationship to Patient

_____ Date of Authorization

_____ Contact Phone Number