



Tenafly Pediatrics, P.A.

Pediatrics & Adolescent Medicine

Medical Release Form

Previous 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
- 704 Palisade Avenue • Teaneck, N.J. 07666 (201) 836-4301 • Fax: (201) 836-5110
- 570 Piermont Road • Closter, N.J. 07624 (201) 768-8811 • Fax: (201) 768-7316

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

