CHILDREN OF JOY
PEDIATRICS
134 Summit Avenue
Hackensack, NJ 07601
(201) 525-0077 Fax(201)525-0072

Medical Release Authorization Form

There will be a Charge of $ 10.00 per each child medical record

I_____ (Parent / Guardian) am requesting the release of my child(ren) complete medical records:

_____	_____	_____/_____/_____,
(Patient ID)	(Last Name, First Name)	(Date of Birth)
_____	_____	_____/_____/_____,
(Patient ID)	(Last Name, First Name)	(Date of Birth)
_____	_____	_____/_____/_____,
(Patient ID)	(Last Name, First Name)	(Date of Birth)
_____	_____	_____/_____/_____,
(Patient ID)	(Last Name, First Name)	(Date of Birth)

I authorize Children Of Joy Pediatrics to release the medical records on my behalf, to my new pediatrician:_____.

(**) Reason For Leaving:_____

_____

I also understand any open balance on the account of my child(ren) must be closed before my records are released._____

(Initials)

Thank You,

_____

Parent /Guardian's Name

_____ Pick-Up date_____

Parent/ Guardian's Signature