RECORD RELEASE AUTHORIZATION

TO: (doctor or hospital)_____

ADDRESS:_____

PHONE NUMBER:_____

FAX NUMBER:_____

I HEREBY AUTHORIZE & REQUEST YOU TO RELEASE TO:

JAY A. LOVENHEIM, D.O., F.A.A.P.
SEEMA MATHEW, M.D., F.A.A.P.
SUSAN YOO, M.D., F.A.A.P.
101 OLD SHORT HILLS ROAD, STE. 105
WEST ORANGE, N.J. 07052
(973) – 325-1115

THE COMPLETE HISTORY IN YOUR POSSESSION, CONCERNING ANY ILLNESS AND/OR TREATMENT DURING THE PERIOD:

FROM:_____TO:_____

NAME OF CHILD/CHILDREN:_____

_____

ADDRESS:_____

SIGNATURE:_____WITNESS:_____
(if relative, state relationship)

DATE:_____