Authorization to Release Medical Records

I hereby authorize _____(facility)

Address: _____

Telephone No._____ Fax No. _____

to release the medical records of:

Patient's Name: _____

Address: _____

Telephone No. _____ Date of Birth _____

To: **KidKare Medical at**
15-01 Brodway avenue Suite#36
Fair Lawn, NJ 07410
Tel No. (201) 773-6171
Fax No. (201) 773-4845

I understand that these records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided by law.

By my signature below, I hereby, knowlingly and voluntarily, authorize KidKare Medical to request my health information.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Relationship to Patient