Record Release Authorization

To:_____
Doctor or Hospital

_____
Address

Fax #_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

WYCKOFF PEDIATRICS
Mondana Yazdi, MD

219 EverestAvenue
Wyckoff, NJ 07481

Telephone (201) 891-4777
Fax (201) 891-3823

THE ENTIRE MEDICAL RECORD (INCLUDING VACCINES/LABS/OFFICE NOTES) IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM

_____TO_____

NAME(S) & Date of Birth: _____

_____

ADDRESS_____

PHONE_____

SIGNATURE_____ Date_____