RECORD RELEASE AUTHORIZATION

TO: _____

Doctor or Hospital

_____

Address

_____ _____

Phone **Fax**

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE RECORDS TO:

HEIGHTS PEDIATRICS

KATERINA SILVERBLATT, M.D.

MARIA BEATRIZ MAIDANA MORENO, M.D.

145 HENRY ST, SUITE 1G

BROOKLYN, NY 11201

T: 718-858-4924

F: 718-522-4954

THE COMPLETE HISTORY OF RECORDS IN YOUR POSSESSION CONCERNING MY CHILD(REN)'S ILLNESS AND/OR TREATMENTS DURING THE PERIOD:

FROM: _____ TO: _____

NAME OF PATIENT: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

PARENT NAME: _____

SIGNATURE: _____ DATE OF REQUEST: ____/____/____

WITNESS: _____