Transfer of Medical Records Consent

I, _____Authorize

Heights Pediatrics
145 Henry Street, Apt 1G
Brooklyn, NY 11201
718.858.4924

To release the records for:

Patient(s)_____

DOB: _____

To Doctor_____

Address: _____

Patient/Guardian Signature_____

Date_____

OFFICE USE ONLY

DATE SENT:_____

COPIES_____

INITIALS OF STAFF_____