# 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_____

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**OFFICE USE ONLY**

DATE SENT:_____

COPIES_____

INITIALS OF STAFF_____