AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Child's Name: _____ Date of Birth: _____
(Please Print)

Child's Name: _____ Date of Birth: _____
(Please Print)

Child's Name: _____ Date of Birth: _____
(Please Print)

Child's Name: _____ Date of Birth: _____
(Please Print)

I hereby authorize and request the complete medical record of the child (ren) listed above be released to:

Downtown Pediatrics
Dr. Vicki Porges
Dr. Anna Zhivotovsky
Lisa Van Brunt, CPNP
36 N. Moore Street
New York, NY 10013
Phone 212-925-3636
Fax 212-925-0633
Email downtownpedaitrics@yahoo.com

_____ _____
Signature of Parent/ Legal Guardian Date