AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients name: _____D.O.B._____

_____D.O.B._____

_____D.O.B._____

I Request and Authorize_____ to release all

Healthcare information of the above patient/patients named above to:

PEDIATRIC ASSOCIATES OF WESTFIELD

Robert Panza, M.D., Jane Presti, M.D., Nicole Panza, M.D.

566 Westfield Avenue, Westfield, N.J. 07090

This Request and Authorization applies to:

*All Healthcare Information

*Immunization Records

Parent Signature: _____Date:_____

This Authorization expires Ninety Days after it is signed