



## Records Release Authorization

To: \_\_\_\_\_  
(Doctor or Hospital)

\_\_\_\_\_  
Address

I hereby authorize and request you to release to:

### **Pediatric Healthcare of LI**

*(Please circle which office location you would like to send your child's records to)*

145 Franklin Place  
Woodmere, NY 11598  
P 516-295-1200  
F 516 295-1207

2592A Merrick Road  
Bellmore, NY 11710  
P 516-295-1200  
F 516-679-5340

The complete history records in your possession, concerning my child/children's  
treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

OR  Newborn Nursery Records

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Parent's Names

\_\_\_\_\_  
Address, City, State, ZIP

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Date of this request: \_\_\_\_ / \_\_\_\_ / \_\_\_\_