PediatriCare Associates

*Pediatric and Adolescent Medicine*

# AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

I, _____, do hereby authorize the release of my
Parent or Legal Guardian

child(s) medical records, including immunizations and reports to be forwarded to:

PediatriCare Associates
901 Route 23 South
Pompton Plains, NJ 07444

PediatriCare Associates
400 Franklin Turnpike
Mahwah, NJ 07430

PediatriCare Associates
20-20 Fairlawn Avenue
Fairlawn, NJ 07410

Parent's please check the appropriate office to which you want your records transferred

Child's Name: _____ D.O.B _____

Child's Name: _____ D.O.B _____

Child's Name: _____ D.O.B _____

Child's Name: _____ D.O.B _____

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE:** _____

Signature of Parent/Legal Guardian: _____Date: _____