Record Release Authorization

To:____
Doctor or Hospital

____
Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

BROADWAY PEDIATRIC ASSOCIATES
Mary Lee Harrison, M.D. F.A.A.P.
Daniel I Schwartz, M.D. F.A.A.P.
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THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM

____________________TO____________________

NAME(S) ____

ADDRESS____

SIGNATURE______________________________ Date______________