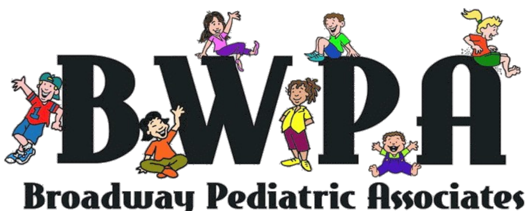

336 Center Avenue
Westwood, NJ 07675
Phone: 201-664-7444
Fax: 201-666-9476
www.broadwaypediatrics.com

Record Release Authorization

I authorize and request the release of my (self) child / children's medical records.

Patient(s): ____

Patient(s) Date of Birth: ____________________________________

Signature of Parent: ____

____
Signature of Patient (if 18 yrs of age or older)

There is a charge of .50 cents per page with a maximum of $25.00 per child and a maximum of $75.00 per family. Additional shipping charges may apply. You will only be billed when the record review is complete and records are ready to be picked up. Records will not be released until a payment is made. For the most efficient release process, please use a credit card.

Type of Card ____
Card # ____
Exp. Date ____
Signature ____

Please select how you would like your records transferred:

☐ I will pick up my records. Please call at ____________________ when they are ready.
☐ Please mail my records to the following address:
(additional shipping charges apply)

____
____
____

Reason for transfer: ____
If due to insurance, please indicate plan name: __________________________________

Thank you,
Broadway Pediatric Associates