MEDICAL RELEASE FORM

AMBOY PEDIATRICS

285 McClellan Street, Perth Amboy, NJ 08861
PHONE # 732-719-4333, FAX # 732-719-4332

NAME of Prior Doctor or Hospital: ____

PHONE # (of Prior Doctor or Hospital): ____

FAX # (of Prior Doctor or Hospital): ____

PATIENT NAME: ____

PATIENT DOB: ____

PATIENT ADDRESS: ____

PATIENT PHONE: ____

*****PARENT SIGNATURE**:*** ____

PLEASE SEND US FOR THE FOLLOWING DATES OF SERVICE: ____________________________________

_____ ALL MEDICAL RECORD

_____ ALL VACCINE RECORDS

_____ ALL GROWTH CHARTS

_____ ALL LAB RESULTS

_____ ALL RADIOLOGY RESULTS

_____ ALL PROGRESS NOTES

_____ ALL CONSULTANT NOTES

OTHER:____________________________

Comments:

____

*** Confidentiality Notice ***

The documentations accompanying this facsimile transmission contain confidential information belonging to the sender that are legally privileged. This information is intended only for the use of the individual or entity. Any other party is required to destroy the information after its stated need has been fulfilled, unless otherwise required by the state law. If you are not the intended recipient, you are hereby notified that disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for return of these documents.