OUTGOING RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE **GPM PEDIATRICS, PC** TO RELEASE MY CHILD/CHILDRENS MEDICAL RECORDS TO:

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE NUMBER/FAX (IF KNOWN)_____

GPM PEDIATRICS, PC

- ❑ **7715 4th Avenue**
  Brooklyn, NY 11209
  (718) 833-2300 TEL
  (718) 836-2305 FAX

- ❑ **1779 Richmond Avenue**
  Staten Island, NY 10314
  (718) 982-6800 TEL
  (718) 982-6830 FAX

PATIENT(S) NAME_____

PATIENT(S) DATE OF BIRTH_____

PATIENT(S) ADDRESS _____

_____

PHONE NUMBER _____ DATE _____

SIGNATURE_____

RELATIONSHIP TO PATIENT _____