RECORDS RELEASE AUTHORIZATION

TO_____

PREVIOUS FACILITY/PRACTICE

_____

FACILITY/PRACTICE ADDRESS

_____

FACILITY/PRACTICE PHONE NUMBER & FAX NUMBER

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

I authorize and request you to release all medical records & details in their possession. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

PATIENT NAME_____

PATIENT DATE OF BIRTH_____

PATIENT ADDRESS _____

_____

PHONE NUMBER _____ DATE _____

SIGNATURE (Parent or Legal Guardian) _____

RELATIONSHIP TO PATIENT _____