RECORDS RELEASE AUTHORIZATION

To: _____
Doctor or Hospital

_____
Address

I hereby authorize and request you to release to:

Dina W. Hanna M.D., F.A.A.P.

PLAZA PEDIATRICS, PC
1950 Highway 27, Suite HH
North Brunswick, NJ 08902
Telephone: (732)940-5511
Fax; (732) 940-0530

the complete history/records in your possession, concerning my children.

Name(s)_____DOB_____
_____ _____
_____ _____

Address_____

Signature_____ Date_____

Name_____ Relationship_____