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: _____