Pomona Pediatrics, PC
Record Release Authorization

Date:_____

Dear Dr._____
_____
_____

Please provide the medical records for the following patient(s):

_____

First Name Last Name DOB

_____

First Name Last Name DOB

_____

First Name Last Name DOB

_____

First Name Last Name DOB

and please send to:

Pomona Pediatrics, PC
4C Medical Park Drive
Pomona, New York 10970
845-362-0202 (p)
845-362-1347 (fax)

_____

Signature Printed Name Date

Relationship to patient (circle one): Self Parent Guardian