Tender Care Pediatrics PC
2322 New Road
Northfield, NJ 08225
(609) 641-0200
Fax: (609) 641-1304

Informed Authorization/Consent for the Release of Medical Record

I hereby authorize Tender Care Pediatrics to obtain/release the medical records of (**Patient Name**): _____ _____ whose Date of Birth is _____ and date of treatment/visit was: _____ to _____ (if left blank entire record is considered).

Release to/Obtain from the address: _____
_____
_____
_____

Records Released for the purpose of: _____

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing; alcohol or drug abuse counseling or testing; and/or H.I.V./A.R.C testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. I also understand that these records may be released via the US Postal Service or by way of facsimile. This authorization/consent will remain in effect for a period of one year from the date stated below, unless revoked in writing by the person to which it pertains (or his or her parent, legal guardian or legally authorized agent), to this office. These medical records are being disclosed under the provision of the applicable New Jersey State and Federal law.

Signature: _____ Date: _____
Relationship to patient(if signed by representative of patient): _____

FOR OFFICIAL USE ONLY
Outstanding Patient Balance: yes no
Outstanding Insurance Balance: yes no
Verification / Confirmation of request: Signature/Phone call/Others _____
Paid for record release yes no Date: _____
Records Released to: Name: _____ Relationship to Patient: _____
See billing before records are released
Cleared by billing, ok to release records Date: _____ Initials: ____