Pediatric Healthcare
of Long Island

Records Release Authorization

To: _____
(Doctor or Hospital)

_____
Address

I hereby authorize and request you to release to:

Pediatric Healthcare of LI

(Please circle which office location you would like to send your child's records to)

145 Franklin Place	2592A Merrick Road
Woodmere, NY 11598	Bellmore, NY 11710
P 516-295-1200	P 516-295-1200
F 516 295-1207	F 516-679-5340

☐ The complete history records in your possession, concerning my child/children's treatment during the period from _____ to _____.

OR ☐ Newborn Nursery Records

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

_____
Parent's Names

_____
Address, City, State, ZIP

Signature:_____ Witness: _____

Date of this request: _____ / _____ / _____