

Records Release Form

To: _____

Date: _____

Re: Child / Children

Name: _____

Date of Birth: _____

By signing this form, I authorize you to release confidential health information about my child/children, including a copy of his/her medical records and vaccination record, to the physician/person/facility/entity listed below:

Maria T Micale, DO, FAAP
Stepping Stone Pediatrics
3350 Highway 138
Building 2, Suite 126
Wall, NJ 07719

Signed: _____

Relationship to child /children _____