Willowbrook Pediatrics, PC
57 Willowbrook Blvd. Suite 421
Wayne, New Jersey 07470
Patricia Papadopoulos MD 973-754-4025(Office) Lisa E. Scofield MD
Wafa Abu-Khraybeh MD 973-638-1969(Fax) Jagoda Bronstein MD

OUTGOING
REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

Patient's Name: _____

Date of Birth: _____

Address: _____

_____

The undersigned authorizes Willowbrook Pediatrics to release said medical records to:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

The patient will tender payment for the cost of copying said records for a fee of $1.00 per page or $100 for entire medical record whichever is less. There is a minimum of 1 week required to copy medical records.

_____ _____
Signature of Patient or Representative Date

_____
Relationship to Patient if Applicable

_____ _____
Witness Date