

# Elliston Pediatrics

Concierge Medicine

## Authorization for Release of Medical Records

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address:

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Name and Address of Provider or Entity to Release this Information:

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Please release the complete medical records of my child/children to:

### **Elliston Pediatrics**

**email: [info@ellistonpediatrics.com](mailto:info@ellistonpediatrics.com)**

**fax: 917-746-9649**

**address: 82 Nassau Street, #60518  
New York, NY 10038**

Signature of Parent / Guardian Authorizing Release:

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Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_