RECORDS RELEASE AUTHORIZATION

CHILD HEALTH ASSOCIATES

666 Plainsboro Road
Suite 1300
Plainsboro, NJ 08536

Phone#: (609) 750-1521
Fax#: (609) 750-1523
Email: chadoctors@gmail.com

Child #1:
Patient Name: _____

Date of Birth: _____

Child #2:
Patient Name:_____

Date of Birth: _____

Child #3:
Patient Name: _____

Date of Birth: _____

Child #4:
Patient Name: _____

Date of Birth: _____

Previous Doctor
Physician/Practice Name: _____

Address: _____
STREET CITY STATE ZIP

Fax Number: _____

I hereby authorize you to release any chart and medical information, including the immunizations, examinations, diagnoses, and treatments rendered from the above name patient(s) to:
Child Health Associates
Dr. Mana Somasundaram

Patient / Parent Signature: _____