

Record Release Authorization

To:

Address

.....

I Hereby Authorize and Request You to Release to:

Kids Care Pediatric Associates, PC
Stuart Feinstein, M.D., FAAP. Sharon Perlman, D.O.
Warren Silberstein, MD, FAAP Karen Coley-Piccirillo, DO, FAAP
2266 Dutch Broadway, Elmont, NY 11003
516.775.0493 516.599.6230
Fax: 516.775.0424
info@kids-care.com

The complete history records in your possession (including any Positive or Negative HIV information) concerning my children:

_____ DOB: / /

_____ DOB: / /

_____ DOB: / /

_____ DOB: / /

Name: Date: / /

Address:

_____ Date: / /

Signature