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, Cynthia Hyacinthe, PNP
Kathy Devarso, CPNP
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