

GALLOWAY PEDIATRICS, LLC

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REQUEST TO RELEASE MEDICAL RECORDS

PLEASE PRINT

Patient Name: _____ Patient Date of Birth _____

Parent or Legal Guardian: _____

Relationship to Patient: _____

By signing this authorization, I authorize

(previous doctor or clinic)

(address)

(city, state, ZIP)

(phone number)

to release a copy of the Medical Records of my child to Galloway Pediatrics, LLC.

Dr. Edwin Lopez-Bernard

Signature of Patient, Parent, or Legal Guardian

Date

Witness

Date