RECORD RELEASE REQUEST

To Eastside Pediatrics
5900 North Burdick St.
East Syracuse, NY 13057

Date: _____

Patient (s) Name(s) *Birthdate(s)*

_____ _____
_____ _____
_____ _____
_____ _____

_____
Name of Parent/Guardian

_____
Signature of Parent/Guardian

_____
_____
Address of Parent/Guardian

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to the above listed patient(s) to:
Eastside Pediatric Group, 5900 North Burdick Street, East Syracuse, NY 13057.

Name and Address of physician or medical practice who will release records to Eastside Pediatric Group: