

*DeVito and Alvarado Pediatric Associates, PLLC*

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**RECORD RELEASE AUTHORIZATION**

**TO:** \_\_\_\_\_  
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**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE RECORDS TO:**

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STATEN ISLAND, NY 10314  
(718) 982-1136 TEL  
(718) 982-1137 FAX**

**PLEASE RELEASE ALL MEDICAL RECORDS IN YOUR POSSESSION**

**DURING THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_.**

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_