AUTHORIZATION FOR TRANSFERING OF MEDICAL RECORDS

I, _____, do hereby authorize the release of my child(s) medical records, inlcluding immunizations and reports to be forwarded to:
Parent/Guardian

Nuheights Pediatrics
2 Brighton Rd, Suite 404, Clifton NJ 07013

Fax: 973-250-2971
Email: info@nuheights.com

Child's Name: _____ DOB:_____

Child's Name: _____ DOB:_____

Child's Name: _____ DOB:_____

Child's Name: _____ DOB:_____

PREVIOUS PEDIATRICIAN'S (OR HOSPITAL) INFORMATION

Name of practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name of Insurance Company: _____

Is your child fully vaccinated? yes or no (circle one)

If not, do you plan to fully vaccinate your child? yes or no (circle one)

Print name of Parent/Legal Guardian: _____

Home Address: _____

Phone Number: _____ Email Address: _____

Signature of Parent/Legal Guardian: _____ Date:_____