

# GRUENWALD & COMANDATORE, MDS

90 Millburn Ave., Suite 101  
Millburn, NJ 07041  
Phone: (973) 378-7990  
Fax: (973) 378-7991

## RECORD RELEASE AUTHORIZATION

I, \_\_\_\_\_, hereby request and authorize you to release the record(s) of:

Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____

The medical records will be mailed to:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I will be picking up the medical records.

Name \_\_\_\_\_  
Telephone # \_\_\_\_\_

OR

### Fee:

I have enclosed the record release fee (\$10/child).

Check

Check# \_\_\_\_\_ Amount \$ \_\_\_\_\_

OR

I will pay upon pick-up.

Credit Card

Amex \_\_\_\_\_ Visa \_\_\_\_\_ MC \_\_\_\_\_ Discover \_\_\_\_\_  
CC# \_\_\_\_\_ Exp \_\_\_\_\_

Cash (*Please do not mail cash.*)

Reason(s) for request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that records will take five (5) days to complete and will be released upon receipt of payment.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date of Signature

*For Internal Purpose Only:*

Manager's Initial \_\_\_\_\_ Date \_\_\_\_\_  
Billed Date \_\_\_\_\_  
Mailed Date \_\_\_\_\_  
Staff Initial \_\_\_\_\_