Edgewater Pediatrics, P.C.
Sushma D. Kaul, M.D.
115 River Road Suite 1003 Edgewater, NJ 07020
Phone: (201)945-9453 Fax: (201)945-9484

Consent for Release of Medical Information

Dear Dr._____
_____has recently become my patient.

I would appreciate it very much if you would send me his/her medical history and any information you think may be useful to me. If you have any questions concerning this request, please contact us at 201-945-9453. A signed consent form from the patients family is as below.

Date: _____
I herewith authorize:
Doctor's Name: _____
Address: _____
City: _____
State/Zip: _____
Phone: _____ Fax: _____
to release to Edgewater Pediatrics above mentioned child's medical history, laboratory reports, x-rays, and any other material regarding medical consultations and treatment he/she received. His/her records should be under the following name:

_____

First Middle Last DOB

_____

Parents/Guardian Signature Date

Thank you for your help.

Sincerely,

Sushma D. Kaul, M.D.