RECORDS RELEASE AUTHORIZATION

To: _____

Address: _____

_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

CORAL SQUARE PEDIATRICS, P.A.

JOEL D. CHERESNICK, M.D., F.A.A.P.
JENNIFER Y. LIANG, M.D., F.A.A.P.

700 Riverside Drive
Coral Springs, Florida 33071
954-753-7870
FAX 954-752-0032

Date: _____

Patient: _____

Signature: _____

Birthdate: _____