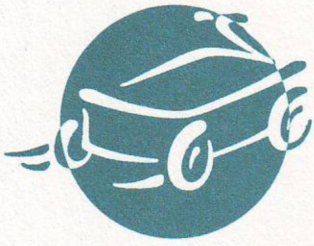

DOUGLAS A. SCHULTZ, M.D.
JOSEPH C. WITTMANN, JR. M.D.
ANN MARIE JOBES, M.D.
SUSAN M. STEAD, P.N.P.

# AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ______________________________________________
Last                    First                    Initial

Address: ______________________________________________
Street                    City                    Zip Code

Telephone: ________________ Birthdate: ________________ Patient# ________________

I hereby authorize ________________________________

________________________________

________________________________

to release copies of medical information from the above named patient's medical record as indicated below for the purpose of review and examination to:

Wheatfield Pediatrics, LLP

2890 Niagara Falls Blvd.
North Tonawanda, NY 14120

- ☐ Entire Medical Record
- ☐ Pertinent Medical History
- ☐ Growth Chart
- ☐ Immunization Records
- ☐ Other ________________________________

________________________________ Date ________________
Signature of Guardian

________________________________ Date ________________
Witness

**WHEATFIELD PEDIATRICS**

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