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Authorization to Release Medical Records

I Authorize the release of medical records for:

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

from: Dr._____ Office Phone:_____

Fax Number: _____

to: Dr._____ Office Phone:_____

Fax Number: _____

Information to be released:

___ Immunization Record _____ Growth Charts ___ Current Well Child Exam

___ Hospitalization Summaries _____ Consultant Letters

___ Labs, X-rays _____ ADHD Records

***** PLEASE MAIL TO THE ABOVE ADDRESS IF RECORDS EXCEDE 25 PAGES *****

I understand that this Authorization is valid for 180 days unless I revoke it in writing sooner. I understand the records disclosed become a part of my child's new medical record and may be subsequently disclosed.

Signed: _____ Date: _____

Parent or Legal Guardian