FIFTH AVENUE PEDIATRICS, P.A.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that nay person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected.

Patient Name: _____ **Date of Birth**: _____

I hereby authorize the release/disclosure of patient's health care information FROM:
(Person or organization): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone # ( )_____ Fax # ( ) _____

I hereby authorize the release/disclosure of patient's health care information TO:
(Person or organization): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone # ( )_____ Fax # ( ) _____

This authorization applies to the following information: All Records_____ Labs _____
Imaging Reports _____ Immunization Reports _____ Other: _____
This information will be used for the following purpose: _____
This consent expires: 30 days _____ Other specified: _____

Signature: _____ **Date**: _____

Relationship to patient: _____
If personal representative, attach copy of letter of administration.

For Office Use ONLY: Date of disclosure: _____ By: _____

<u>*IF OVER 25 PAGES, PLEASE MAIL RECORDS*</u>