176 N. Village Ave., Suite 1D
Rockville Centre, NY 11570
(516) 766-4094 (p)
(516) 766-4092 (f)
www.abcpeds.com
reception@abcpeds.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:

Name: ____

Address: ____

City/State/Zip: ____

Telephone: ____

Fax: ____

I hereby authorize the release of information from the medical record of:

Patient Name: ___________________________________ Date of Birth: ______________________

Patient Name: ___________________________________ Date of Birth: ______________________

Patient Name: ___________________________________ Date of Birth: ______________________

Patient Name: ___________________________________ Date of Birth: ______________________

Please Release Information To:

ABC Pediatrics, P.C.
176 North Village Avenue, Suite 1D
Rockville Centre, NY 11570
516-766-4094 (phone)
516-766-4092 (fax)

Information Requested:

□ Immunization Record/Growth Chart/Last Well Visit □ Labs/X-Rays

Informed Consent for Release of Confidential Information.

- I understand that I may revoke this consent in writing at any time except to the extent action has already been taken.
- I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
- I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, and test results.
- I understand that the information released is for the specific purpose stated above.

____ ______________________________

Signature of Patient or Legal Representative Date

____

Relationship to Patient