PEDIATRICS AND ADOLESCENT MEDICINE, P.C.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date: _____

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

_____

I request and authorize _____
to release healthcare information of the patient named above to:

Check One Box

☐ Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

OR

☐ Pediatrics and Adolescent Medicine, PC
240 Indian River Road, Suite B-1
Orange, CT 06477
Phone: 203-795-6025 Fax: 203-799-1554

This request and authorization applies to:

☐ Immunizations

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All Healthcare Information

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____
Relationship to Patient