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 any 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 the following:

_____
Person or organization to release information

_____
Street address

_____
City State Zip code

_____ _____
Phone number Fax number

I hereby authorize the release/disclosure of patient's health care information TO the following:

_____
Person or organization to receive information

_____
Street address

_____
City State Zip code

This authorization applies to the following information:
_____ All records _____ Labs _____ Imaging reports _____ Immunization records

_____ 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:**_____