



## RECORD RELEASE AUTHORIZATION

I hereby authorize and request you to release to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

The records in your possession, concerning my child's illness and/or treatment during the following period

From: \_\_\_\_\_ To: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patients Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_