Ayuste Pediatrics

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AUTHORIZATION TO RELEASE INFORMATION

Copy of immunizations only $10 charge
Copy of entire records $20 for each child

Please Print Clearly

Patient's Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Phone: (___) _____ Date of Birth: _____ SS#: _____

I authorize (name of previous doctor(s)) _____ to release medical information from my medical records and send it to:

Name of New Physician _____

Address: _____
(Street) (City) (State) (Zip)

I authorize you to release my entire record to the physician named above subject to the following limitations:

___ No limitations
___ Only information related to the following
- ___ HIV/AIDS
- ___ Mental Health
- ___ Substance Abuse
- ___ Other: _____

___ Any medical records from other physicians or providers

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed: _____ Date: _____

Printed Named: _____

Relationship to Patient: _____

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AYUSTE PEDIATRICS

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