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JUST KIDZ PEDIATRICS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

I request and authorize the release of healthcare information of the patient(s) named above from:

Doctor or Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

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

☐ All immunization records, lab results, and specialist correspondence.

☐ Other: _____

Patient or Parent Signature: _____ Date Signed: _____