Authorization for Release of Medical Information

Name of Previous Pediatrician/Office: _____

Phone Number_____

Patient's Name: _____Date of Birth: _____

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including psychiatric and/or psychological information and information pertaining to AIDS and/or Human Immune Deficiency Virus Testing which may be a part of my medical records, covering the periods from birth to present.

These records are to be forwarded to:

IMMUNIZATIONS
LAST WELL VISIT
GROWTH CHART

Mahoney Pediatrics, P.A.
12983 Southern Blvd, Suite 100
Loxahatchee, Fl 33470
Phone: 561-793-2500
Fax: 561-793-2510

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these records.

_____ _____
(witness) (signed)

_____ _____
Relationship, if other than patient Print name