VILLAGE PEDIATRICS, LLC

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Authorization to Release Medical Records

Patient's Name:_____

Date of Birth:_____ SS# :_____

Address:_____

City:_____ State:_____ Zip_____

Telephone Number:_____

Date of Treatment:_____

I, the undersigned, hereby authorize:

Name:_____ Location:_____

(P)_____ (F)_____

Address:_____

City:_____ State:_____ Zip:_____

The specific information to be used or disclosed is as follows:

Complete health record_____ Operative reports_____ Pathology reports_____

Laboratory reports_____ Radiology reports_____ Cardiology reports_____

Other testing results_____ Emergency room discharge summary_____

I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that I have the right to inspect and copy the information to be used or disclose is pursuant to this authorization. I understand that once this information is received by the authorized person or organization then may be subject to redisclosure and may no longer be protected by federal privacy laws.

I herby authorize the above use and disclosure.

Signature of Parent or Legally Authorized representative:_____

Date:_____