Association of Childcare Physicians, Ltd.

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AUTHORIZATION FOR RELEASE OF INFORMATION

RE:_____ _____
Patient's Name (Print) Date of Birth

_____ _____

_____ _____

_____ _____

RE:_____ _____
Parent's Name (Print) Chart #

☐ Release records TO Association of Childcare Physicians, Ltd. From:

☐ Release records FROM Association of Childcare Physicians, Ltd. To:

_____
Doctor or Medical Center (Print)

_____
Address

I authorize you to furnish a copy or summary of medical records on the above named child/children to the above named doctor/medical facility. I release you from all legal responsibility or liability that may derive from this authorization.

Reason for leaving:_____

AREAS OF SPECIFIC INTEREST OR CONCERN

ALL_____ Illness/Hospitalization_____

Immunizations_____ Lab Studies/Consultation_____

Signed_____ Date_____
Parent/Legal Guardian