Authorization to release Healthcare information

PATIENT NAME: _____DOB:_____

____ This is an authorization for Baker Pediatrics to **obtain** medical information from the physician/organization named below.
____ This is an authorization for Baker Pediatrics to **release** medical information to the physician/organization named below.

Reason for record release:

_____
Physician/OrganizationName_____
Address:

_____
City: _____ State: _____
ZipCode_____
Phone: _____
Fax: _____

THIS RELEASE REQUESTS ALL RECORDS IN YOUR POSSESSION, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATION RECORDS AND LABORATORY TESTING RESULTS

Name: _____ Signature: _____
Relationship to Patient: _____
Phone:_____
Witness Signature: _____
Date: _____