ALPHA PEDIATRICS,PA

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RELEASE FORM

Be sure to download and save this document to your computer. This form can be filled out on your computer and emailed to alphapedi01@gmail.com or print the form out and bring it to the office filled out. Thank You!

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I _____ Authorize Alpha Pediatrics to obtain information from:

Facility Releasing Information: _____

Address: _____

Phone: _____ Fax: _____

For the following patient(s):

Name: _____ DOB: _____

Name: _____ DOB: _____

Type of Record Requested:

- ☐ Complete records.
- ☐ Labs/ X-rays.
- ☐ Immunization record.
- ☐ Other.

Purpose for this Request:

- ☐ Transfer of Care
- ☐ Personal
- ☐ Other (Please specify)

By signing below, I authorize Alpha Pediatrics to obtain medical information. I understand that I have the right to revoke this authorization. Revocation must be made in writing and received by Alpha Pediatrics PA, and will not apply to information that has already been released. I understand that there may be a charge for these records, as state and federal laws allow.

Parent's Signature _____ Date _____