AUTHORIZATION FOR RELEASE OF CONFIDENTAL PATIENT INFORMATION

Patient Name: _____ SSN: _____

DOB: _____ Telephone Number: _____

I HEREBY AUTHORIZE KATZ PEDIATRICS TO RELEASE MEDICAL INFORMATION TO:

Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

☐ Full Medical Record

☐ Immunization Record

☐ Physical Exams and Growth Charts

☐ Specified Items Requested _____

Any information, including diagnosis and records of treatment or examination rendered to me including any Federal and State protected information under appropriate Statue, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) test results and treatment. I understand that this authorization will remain in effect for (1) year or until I revoke it in writing, to an authorized employee of Katz Pediatrics. I have read Katz Pediatrics' Notice of Privacy. I hereby release Katz Pediatrics and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Parent or Guarantor Date

_____ _____ _____

Signature of Empowered Representative Relation to Patient Date