



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/Organization Name: _____

Address: _____

City: _____ State: _____

Zip Code _____

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: _____