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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Pediatric Gastroenterology & Nutrition Associates to release my (if patient is an adult) or my child's medical records to:

Name : ____

Address: ____

Phone: __________________________ Fax: _____________________

Patient Name: ____

Social Security Number (if available): _________________________________

DOB: ____

Signature of adult patient/parent/guardian: ____________________________

Social Security Number: ____

Date: ____

(This authorization is valid only for the release of information from the above-named individual(s), hospital, or organization and shall be valid unless revoked in writing by the adult patient, patient's parent or legal guardian.)