

Surf and Sand Pediatrics

Phone 9124563605 Fax 9124563531

Release of Medical Information

Authorization to Disclose

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Parent/Guarantor Name |  |
| Address |  |
| Phone Number |  |

Reason for records release request

* Transfer of care
* Self
* Specialist
* Other:

Records request

* Medical records from last 2 years
* Limited records from specific date:
* Complete Medical record content

Signature of patient/parent:

Date:

Previous Physician/Office Name:

Phone: Fax: