Quakertown Pediatrics

Eduardo A. Cevallos, M.D.
Rima L. Strassman, M.D.
Bobbie J. Monaco, C.R.N.P.
Renee Bennett, C.R.N.P.
Linzy Peloso, C.R.N.P.

Authorization to Release Medical Records Information

Send Records To: _____

Address _____

City,State,Zip Code _____

Phone/Fax _____

I authorize the release of records for the following patients:

Patient Name _____ **Date of Birth** _____

Patient Name _____ **Date of Birth** _____

Patient Name _____ **Date of Birth** _____

Patient Name _____ **Date of Birth** _____

Release the following records (please circle one)

_____ **1. Copy all patient records**
_____ **2. Only records generated by Quakertown Pediatrics.**
_____ **3. Only some portion of records maintained at this facility (dates or treatment, specify below)**

_____

_____

If you do not want certain portions of your child's medical records released, please read this section carefully and initial the boxes pertaining to specific information you do not want released. Otherwise, the record will be as specified above.

Substance Abuse, if any _____ **Psychiatric conditions, if any** _____
HIV/AIDS **Other, if other specify** _____

_____

_____

I understand that I may revoke this authorization at any time, and that unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. A copy of this authorization is as valid as the original.

_____ _____
Patient or parent signature **Print Name/Relationship to the patient**

_____ _____
Daytime Phone **Date**

99 N. West End Blvd, Ste. 110 Quakertown, PA 18951
Telephone 215-536-1915 *Fax 215-536-9189*
www.quakertownpediatrics.com