MORNINGSIDE PEDIATRICS
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To:_____

_____

_____

Re:_____ D.O.B._____

Re:_____ D.O.B._____

Re:_____ D.O.B._____

This child has come under our care and supervision. In order to completely evaluate this child's general health and development, we would like to request the following medical information:

( ) All Medical Records
( ) Medical and Treatment Summary
( ) Growth Statistics
( ) Immunization Records
( ) Hospitalization Summary
( ) Laboratory Reports
( ) Radiographs and/or Reports
( ) Other:_____

I/We, the undersigned, do hereby authorize the release and forwarding of the above requested medical information.

Signature:_____ Date:_____

Relationship to Patient:_____