PEDIATRICS AND ADOLESCENT MEDICINE, P.C.

Joseph H. Zelson, M.D., F.A.A.P.
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Cindy Wechsler, A.P.R.N., C.P.N.P.
Elyse Borsuk, A.P.R.N., C.P.N.P.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date: _____

Patient's Name: _____

Date of Birth: _____

Patient's Address: _____

_____

I request and authorize _____

_____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other _____

Patient/Parent/Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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