

## PEDIATRICS AND ADOLESCENT MEDICINE, P.C.

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### 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 \_\_\_\_\_

CONFIDENTIALITY NOTE: THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS CONFIDENTIAL AND INTENDED FOR THE USE OF THE INDIVIDUAL NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, OR COPY OF THIS FAX IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, IMMEDIATELY NOTIFY THE SENDER AT THE TELEPHONE PROVIDED ABOVE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ADDRESS BELOW. THANK YOU.

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Patient/Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

