Newtown Center
PEDIATRICS
Building a Strong Foundation for Healthy Living

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ DOB:_____

Address:_____
Street City State Zip

I hereby authorize:

☐ Newtown Center Pediatrics ☐ Other Facility/Provider:_____

To release the following information on the above named individual:

- ☐ Entire Medical Record
- ☐ Immunizations
- ☐ Lab Results
- ☐ Radiology Results
- ☐ Other _____

Release to:

☐ Newtown Center Pediatrics ☐ Other Facility/Provider:_____ ☐ Patient/Parent

For the Purpose of:

- ☐ Personal Records

Medical Records Fee:

We gladly provide the first copies of medical records free of charge, but I understand a $25.00 fee will be assessed for any additional copies requested.

Patient Signature (18 or older) _____ Date:_____

Parent or Guardian Signature (17 or younger) _____ Date:_____