Medical Release Form

Patient's Information

Patient Name :____________________ Date Of Birth :____/_____/_____

Address :____________________________ City :___________________

State: _________________ Zip Code : ___________

Phone Number : __________________

Email:____________________________

Previous Doctor's Office Information

Doctor's Name: ____________________

Address :_______________________________ City :_______________________

State : ____________________ Zip Code :______________

Phone Number :____________________ Fax :________________________

Email:______________________________

Send Patient's Information To

Doctor's Name : Roger Rivera , MD

Address : 215 Harrison Ave **City : Harrison**

State : New Jersey **Zip Code : 07029**

Phone Number : 862-955-3183 **Fax : 862-955-3189**

Email : bbpediatricsgroup@gmail.com

I __________________ (Name), hereby grant permission for you to release confidential health information about ,e , by releasing a copy of my medical record , or a summary or narrative of my protected health information, to the physician/ person/ facility / entity

___________________________ **Date:** _____________

Printed Name

_________________________ **Date:** _____________

Signature

INFORMATION REQUIRED

***LAST PHYSICAL * VACCINE RECORD * LAST BLOODWORK**

*** ANY SPECIALIST REPORTS**