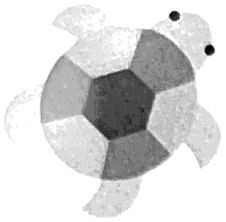

Coastal Pediatric Care

CoastalPedsCare.com

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO STEPHEN G. NELSON, now known as, COASTAL PEDIATRIC CARE

I authorize the named health care provider to release the information or records specified to:

Provider (name and address)	Patient (Include Date of Birth)

( ) Office Notes ( ) Lab Reports

( ) Radiology Reports ( ) Consultation Notes / Reports

( ) Other (specify)_____

Extent or nature of records to be released_____
(Example, specific hospitalization or visit)

This information will be used for the purpose of
( ) Investigating an allegation of abuse ( ) Legal Representation
( ) Providing Advocacy Services ( ) Other Activities

I understand that I can revoke this authorization at any time by writing to the health care provider. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care, or payment for care, will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Signature _____Date_____

Printed Signature _____