Sunrise Pediatrics,PLC

Dr. Sonal Shah

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Authorization for Release of Medical Information

I, _____, parent/guardian of _____

Authorize _____ to release all his/her medical records to

Dr. Sonal Shah at Sunrise Pediatrics. Records can be mailed or faxed to the above office.

This authorization is valid for six months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand that I cannot revoke this authorization retroactively for information already released.

_____	_____	_____
Patient name	Date of Birth	Date
_____	_____	_____
Legally authorized representative	Relationship to patient	Date
_____		_____
Witness		Date