

Palm Beach Pediatric Gastroenterology

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RELEASE OF MEDICAL RECORDS TO PALM BEACH PEDIATRIC GASTROENTEROLOGY

I, _____ do hereby authorize the release of
medical records for my child _____ whose date
of birth is _____ to:

Palm Beach Pediatric Gastroenterology

5325 Greenwood Ave., Suite 304,

West Palm Beach, FL 33407

F: 561-863-8155

E: pbpedsgifax@Gmail.com

Signature: _____ Relationship to Patient: _____

Date: _____