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

4631 N. Congress Ave., Suite 101,

West Palm Beach, FL 33407

F: 561-863-8155

E: pbpedsgifax@Gmail.com

Signature: _____ Relationship to Patient: _____

Date: _____