University Pediatric Associates

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INFANTS, CHILDREN AND ADOLESCENTS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____hereby authorize:
(Parent/Guardian: Please print name)

UNIVERSITY PEDIATRIC ASSOCIATES, P.A.

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To release medical records on:

Patient Name	Birth Date
_____	____/____/_____
_____	____/____/_____
_____	____/____/_____
_____	____/____/_____

Release To:

Name(s): _____
Address: _____
City, State, Zip: _____
Current Phone#: _____

****If moving please provide change of address and current phone #****

Signature: X_____

Print Name: _____
Date: _____/_____/_____

Why are you leaving: _____

******Any current insurance balance not covered by insurance will become the responsibility of the insured.******