BIDABADI Pediatrics

Authorization to Release Medical Records

To:_____
(Provider/Practice Name)

_____
(Address)

_____
(Phone and Fax Number)

I,_____, hereby authorize the release of my child(ren)'s medical records to Bidabadi Pediatrics. Please mail or fax my child(ren)'s records to the information provided below:

Bidabadi Pediatrics
3086 Route 27
Suite 8
Kendall Park, NJ 08824
Phone: 732-422-0393
Fax: 732-821-0903

Patient Information:

Child 1: Name:_____ Date of Birth:_____/_____/_____

Child 2: Name:_____ Date of Birth:_____/_____/_____

Child 3: Name:_____ Date of Birth:_____/_____/_____

Information to be disclosed: I authorize the release of the following health information: (check applicable box below)

☐ All of my child(ren)'s health information, including information relating to any medical history, mental or physical condition, and any pertinent treatment received

☐ ONLY the following records or types of health information_____

☐ Records related to the following date range: From: _____/_____/_____ To:_____/_____/_____

By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____

(Parent/Guardian Signature) (Printed Name of Parent/Guardian) (Date)