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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send actual copies of the following information to Aasha Pediatrics, Inc.:

\_\_\_\_\_ Hospital Chart                      \_\_\_\_\_ X-ray Report(s)  
\_\_\_\_\_ Birth Records                      \_\_\_\_\_ Laboratory Report(s)  
\_\_\_\_\_ Office Chart                      \_\_\_\_\_ Vaccine Record(s)  
\_\_\_\_\_ Records in the chart from previous physicians / facilities  
\_\_\_\_\_ Other: \_\_\_\_\_

Any and all information may be released, except as specifically indicated below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regarding Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____

Reason for requesting records: \_\_\_\_\_

This authorization expires **1 year** from the date signed below.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

If not signed by patient, please indicate relationship: \_\_\_\_\_ Parent or guardian of minor patient  
\_\_\_\_\_ Personal representative of minor patient