AASHA PEDIATRICS, INC.
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____
Doctor/Office Name

_____
Address

(_____) _____ (_____)_____
Phone Number Fax Number

Please **FAX/MAIL** copies of the following information to Aasha Pediatrics, Inc:

___ Hospital Chart
___ Birth Records
___Office Chart
___X-ray Reports
___ Laboratory Reports
___ Vaccine Records
___ Records in the chart from previous physician / facilities
___ Other: _____

Regarding Patient Name Date of Birth

_____ _____

_____ _____

_____ _____

Signed: _____ Date: _____

Printed Name: _____ Phone# _____

If not signed by patient, please indicate relationship:___ Parent/guardian of minor patient
___ Personal representative of minor patient

Authorization valid for 90 days only, and may be revoked in writing at any time prior to 90 days by notifying the office.