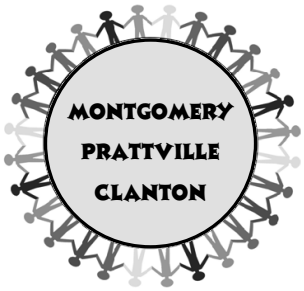

MONTGOMERY PEDIATRIC ASSOCIATES, P.A.
420 COTTON GIN ROAD
MONTGOMERY, ALABAMA 36117
PHONE: (334) 260-9129 FAX: (334) 260-9665

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____ Phone/Cell # _____

Patient's Address: _____

I authorize Montgomery Pediatric Associates, P.A. to release health information to:

Facility to receive health information: _____

Address: _____

Phone: _____ Fax: _____

Information to be released:

❒ History & Physical Exams ❒ Immunization Records

All information I hereby authorize to be released from Montgomery Pediatric Associates, P.A. will be held strictly confidential and cannot be released by Montgomery Pediatric Associates, P.A. without written consent. I understand the authorization will remain in effect for ninety (90) days unless I specify and earlier date. I understand that after signing this release my child is no longer a patient of Montgomery Pediatric Associates, P.A. and there is a processing period of up to 30 days.

Signature: _____ Relationship to Patient: _____

Address: _____

Phone: _____ Date Signed: _____