Newark Pediatrics
314 E. Main Street • Suite 101 • Newark, DE 19711
Phone (302) 738-4800 • Fax (302) 738-8750 • www.newarkpediatrics.com

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Instruction: Complete this form when requesting release of Health Information from Newark Pediatrics, P.A.

PLEASE COMPLETE ALL AREAS OF THIS FORM

Patient Name:_____D.O.B._____

I authorize Newark Pediatrics, P.A. To release my health information to:

Office/Doctor:

Address:

Fax Number and Telephone Number:

_____

These records are needed for the following reason:_____

_____

Do not include the following records:_____

_____

Expiration of this authorization: This authorization expires in 180 days OR upon the following date or event:_____

Specify date or event

Revoking this authorization: This authorization may be revoked at any time but is not retroactive for requests that have been complied with In good faith. To revoke this authorization, please provide a written Request to this office.

_____ _____ _____

Signature of Parent/Guardian Telephone # Date