Grello Pediatrics P.C.

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Date: ________________________________

I authorize _________________________________ to release my records (PHI) indicated below.

To: __________________________________

(Name of practice, Agency, or Institution)

____

(Address)

Describe the PHI information in which you want released, include dates of service or treatment period.

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I release Dr. ____________________ from any laws related to disclosure of confidential or privileged information and understand that the information released may be subject to disclosure by the recipient and not protected by privacy laws. I understand I may not revoke for any actions taken by the office before receiving my written revocation.

Patient Name: ____ Date: _______________

Signature or Authorized Signature: ____

Relationship to Patient: ____