



AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT INFORMATION

Patient Last Name First Name MI Date of Birth
Street Address City State Zip Code

Records I Would Like Released:

- All Records From the Last Two Years (including Well Visits, Sick Visits, and Phone Messages)
Immunization Records & Growth Chart
Specialist Notes From the Last Two Years
Other (Please Specify):

I authorize the medical records listed above to be released by:

Medical Provider Name Address Phone #

I authorize the medical records listed above to be released to KIDS PLUS PEDIATRICS at:

- Cranberry/Seven Fields Office | 671 Castle Creek Drive, Seven Fields PA 16046 | Fax: 724.778.8959
Pleasant Hills Office | 810 Clairton Blvd, Pittsburgh PA 15236 | Fax: 412.466.7137
Squirrel Hill/Greenfield Office | 4070 Beechwood Blvd, Pittsburgh PA 15217 | Fax: 412.521.6512

I understand that:

- I may revoke this authorization at any time, in writing, before the information has been released;
The released information may be released to other parties as necessary and appropriate.

Purpose of Medical Record Release:

- Medical Care Insurance Claim Other (Please Specify)
Legal Investigation Insurance Application

Signature of Patient or Personal Representative

Name Date
If Personal Representative, Print Name
Relationship