

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:		Date of Birth:	
I,	_, hereby authorize <u>Wade</u> -7	<u>Fownend Pediatric Associates</u> to obtain ()	
		ntment dates:	
	_Consultations _History & Physical	HIV Related Info* Drug & Alcohol Related Info* Other:	
INFORMATION TO BE RELEAS Individual or Organization:			
Address:			
reliance thereon) by written or oral o practice, under Pennsylvania Law (A	communication to the medical act 148). If psychological repo	to the extent that action has been taken in l record custodian of this physician(s)' medical orts are to be sent, I have been informed of my Act 1984, to inspect the information to be	
		FROM THE DATE SIGNED UNLESS E ON:(CANNOT MO/DAY/YR	
Signature of Patient/Legal Guard	ian	Date	
Witness	Relationship/Title	Date	
INSTRUCTIONS: 1. Complete all blanks			

*Checking these blanks will allow release of specific information to the above named individual/organization.

Return form with original signature(s).
 Return for "Attention Medical Records."