SHUKLA PEDIATRICS

Authorization of Release of Medial Information

I request and authorize Shukla Pediatrics to release health information of:

Patient Name: _____ D.O.B: _____

Phone: _____

Address: _____

Email: _____

To:

Name: _____

Address: _____

Phone: _____ Fax: _____

This request for authorization applies to:

☐ Immunization Record ☐ Entire Copy ☐ Other: _____

I understand that:

- I must provide a copy of Identification (State ID) for release of records. There may be a charge for the request for records.
- My right to healthcare treatment is not conditioned on this authorization.
- Release of sensitive information regarding HIV/AIDS, Substance Abuse and Sexually Transmitted Disease, requires a separate release form.
- I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation.

Self/Parent/ Guardian Printed Name: _____

Relation to Patient: _____

Self/Parent /Guardian Signature: _____ Date: _____