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MEDICAL RECORDS INFORMATION AUTHORIZATION & CONSENT RELEASE

Release To: TREASURE VALLEY PEDIATRICS

From (Dr or Clinic Name):

1620 S. Celebration Ave
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Fax: 208.884.3058

305 E. Jefferson, Suite 101
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450 W. State St. Suite 100
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Phone or Fax: _____

I AUTHORIZE AND REQUEST YOU TO RELEASE AND FORWARD ANY AND ALL MEDICAL RECORDS OR INFORMATION IN YOUR POSSESSION FOR:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Authorized Signature: _____ Relationship To Patient: _____

Address: _____

Phone Number: _____ Date: _____