RAYNHAM-TAUNTON PEDIATRICS

876 BROADWAY
RAYNHAM, MA 02767
PH: 508-824-9500 F: 508-824-9507
info@raynhamtauntonpediatrics.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____
(**PATIENT NAME)** **(DATE OF BIRTH)**

_____ _____
(**ADDRESS)** **(TELEPHONE)**

- Hereby authorize RAYNHAM-TAUNTON PEDIATRICS to release a summary of my medical records to:

Phone #_____ Fax#_____

- Hereby authorize _____

To release a summary of medical records to RAYNHAM -TAUNTON PEDIATRICS

Phone #_____ Fax#_____

This authorization will expire in 90 days from date of signature.

SIGNATURE OF PATIENT (or parent/legal guardian)

Date

$30 charge for records printed out for pick up or mail. Payment is due before records are printed.
Faxed Summary-no charge

Reason for Transfer:

_____

Specific information or dates of services needed:

_____