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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION & X-RAYS

- **Print, complete, and submit this form by mail, fax, or email.**
- **Please allow 5-7 days for processing. Note that a charge of $15 per x-ray copy is due at the time of release.**

Patient Name _____ Date of Birth _____

I, the undersigned, hereby authorize that my child's medical records be forwarded to the following:

Name of Facility or Physician _____

Address _____

Phone Number _____ Email Address _____

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____

Address _____

Phone Number _____ Email Address _____

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