

AMHERST PEDIATRICS

Date: _____

Patient's Name: _____ DOB: _____

Address: _____

The undersigned hereby authorize the disclosure of information from Amherst Pediatrics.

TO: _____

Purpose or need for Disclosure: _____

Covering records for the period from _____ to _____.

The parent/legal guardian must sign this authorization form for any child under the age of 18, or any child who is physically unable to sign. It is also understood that the above described information may be released and may include dates, history of illness, social history, diagnostic and therapeutic information, including psychiatric care and any treatment for alcohol and drug abuse. Any exception to the release of information is as follows:

Witness _____ Signed _____

Date _____ Date _____

There is a fee of \$0.50 per page with a maximum of \$10.00 which will be billed to the patient.