Thomas F. Cozza, M.D.
Charles J. Francemone, M.D.
Jamie Hendrie, P.N.P.
Nga T.T. Le, M.D.
Nicole E. Mackey, P.N.P.

Albert J. Maggioli, M.D.
Maureen E. Montgomery, M.D.
Russell S. Vaughan, M.D.
Bonnie L. Cullen, P.N.P.

a practice dedicated to personalized child care from cradle to college

Date: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

The undersigned hereby authorizes the disclosure of information from Amherst Pediatric Associates:

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 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:

_____

_____

Signed _____ Date _____

Witness _____ Date _____

Please note: There will be a per-page fee for records billed to the responsible party as follows:

3-30 pages - $10
31-60 pages - $15
Over 60 pages - $25