HEALTHY START PEDIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____/_____/_____

Address: _____

Phone No: _____SSN#: _____

I hereby authorize _____

Phone No: _____ Fax No: _____

to release the following medical information for the purpose of ( ) continuity of care or ( ) other to:

Healthy Start Pediatrics
525 South Drive, Suite 201
Mountain View, CA 94040

Please release:
( ) Complete records

( ) Other (Please be specific)

Signature: _____ Date: _____

Relationship to patient: _____